# PUBLIC HEALTH NURSING

*Official Organ of the National Organization for Public Health Nursing, Inc.*

VOLUME 30 JUNE 1938 Number 6

## "MIRROR, MIRROR ON THE WALL—"

PUBLIC HEALTH NURSING has come of age! It has passed the stage of exuberant, uncritical growth and expansion and is beginning to examine itself analytically, objectively—a sign of maturity and adulthood. Certainly, the straws in the wind at the 1938 Biennial Convention at Kansas City, Missouri, seemed to point to this conclusion. Self-study is the theme of today's thinking.

This emphasis recurred in meetings, in conversations everywhere at Kansas City. It ran the gamut of the round tables, where perhaps the most serious discussions took place. Here it began where all really effective self-analysis must begin—with the staff nurse. In some ways the most significant event at the entire convention was the challenge by a staff nurse: "There is nothing more detrimental to an agency's standards than for the nurses to develop . . . complacency about their work. However, there is a way for the nurse to avoid this danger and that is through self-analysis." ("A Staff Nurse Analyzes Her Own Work," to be published in the July issue.)

The round table of administrators in larger agencies echoed the same thought in terms of specific evaluation of quality of visit as it relates to cost of visit, admitting frankly our total lack of objective evidence to prove that a costlier visit is also a better visit, and urging that studies be made which will show how various factors affect the quality of the visit.*

The school nurses invited an educator to dissect and scrutinize critically the school health program; and the industrial nurses applauded when a personnel manager pointed out the mistakes and pitfalls in their job.

In the board and committee members' round table, we find the board of a smaller agency undertaking an educational program for itself which ended in a survey of its own community needs and how effectively they were being met.

Leaving the meetings and walking through the spacious halls of the auditorium, a listening reporter would have heard many variations of this theme in the informal conversations among groups chatting here and there.

How do we know that our teaching is really effective in influencing the be-

*A committee of the National Organization for Public Health Nursing is working on a plan for such a study.

havior and habits of families in such a way as to bring about better health? What actually happens in the relationship between the nurse and the family in the home or at the school or clinic; between the nurse and the worker in industry? What motivations are we using to bring about changes in the health behavior? How do we know that our program for the education of nurses is resulting in better service to the family and the community? How can we evaluate what we have accomplished?

These are some of the searching questions that nurses are asking themselves; that board members are asking nurses to ask themselves.

A CHALLENGING and startling milestone in this self-analysis is the picture we see of ourselves in the mirror held up to us by a recent study by the U. S. Public Health Service, a preliminary report of which was made by Dr. Mayhew Derryberry at the convention. (See page 357.) With the coöperation of health department nursing services, trained observers have gone into the homes with public health nurses, and inconspicuously made verbatim copies of the conversations which took place. This is the first entirely objective picture we have ever had of what transpired between nurse and family.

After making allowance for the restraint upon the nurse's effective functioning and upon the whole situation caused by the presence—however self-effacing—of a third person, this candid-camera photograph of our activities still furnishes us with a veritable gold mine of data for studying ourselves. Our ability to face unflinchingly its implications is probably a measure of our real maturity. Its possibilities as a tool for improvement of our service are tremendous.

The final report of the study will be published in *Public Health Reports*. Other studies, to follow it, are already being planned. Prior to this, the only comprehensive study which ever attempted to measure quality of service was the *Survey of Public Health Nursing* made by the N.O.P.H.N. and published by The Commonwealth Fund, New York City, in 1934.

If the sentiment of the convention-goers was correctly gauged, there will be a demand for still other studies to measure and evaluate, by the most scientifically accurate methods available, the quality of nursing service which we offer to the community. With such studies we shall be able to set for ourselves standards which we can be reasonably sure are sound. We can plan our administrative methods and educational program on a sound foundation. And we can more accurately tell the community which is asking for a high quality of service whether it is getting value received for the money it spends.

P.P.

## OUR FINANCES

Those of our readers who are interested in our present financial status will find a detailed statement of N.O.P.H.N. income and expense for 1937 in the March 1938 issue of PUBLIC HEALTH NURSING, page 185. The April 15, 1938, issue of *Listening In* also contains a brief report of finances for the biennial period, 1936 and 1937.

**TOTAL REGISTRATION AT THE BIENNIAL CONVENTION—5436**

GRACE ROSS, R.N.
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Treasurer

# A Biennial in the "Heart of America"

By ALMA C. HAUPT, R.N.
Director of Nursing Bureau, Metropolitan Life Insurance Company, New York, New York

**Those who did not attend the 1938 Biennial Convention —and those who did—can visualize those eventful days like an unfolding panorama in these colorful impressions**

AS I DROVE from the Union Station in Kansas City to the President Hotel, I knew I was in the convention city, for along the streets I saw well-dressed women wearing badges, carrying blue programs, and clutching at large shopping bags literally overflowing with "loot"—the samples so generously given out by the exhibitors. Stepping into the hotel lobby, I plunged from the quiet seclusion of an individual traveler into the dizzy whirl of association with almost five thousand nurses, board members, and friends who came to the "Heart of America" for renewal of friendships, review of progress in nursing, and fresh inspiration and guidance for the future.

The Kansas City convention will long be remembered as the "least painful convention ever held." The Municipal Auditorium was perfect for our needs, with ample space, fine acoustics, and plush seats so comfortable that a wink or two of sleep was only averted by the stimulus of the speakers. The stages were gay with flowers; monitors and ushers were courteous and efficient; and the blue programs were so well indexed and so clearly put together that only a few people got lost or failed to find the desired place at the right time.

Imagine entering the exhibit hall to find it possible to register in five minutes and to have tickets for breakfasts, luncheons, and dinners for the whole week in another ten minutes. Early completion of these necessary formalities gave one a comfortable feeling about exploring the adjacent exhibits which were unusually attractive with displays of great educational value well set off against soft yellow backgrounds and staffed by men and women eager to render service. It was interesting to observe that the size of a crowd about an exhibit was largest where the attendant was most active in reaching the public. I talked with many an exhibitor who said the arrangements were ideal and the nurses very responsive.

Just one more word about the arrangements, which make such a great contribution to one's ability to "take in" a convention. The headquarters hotels for the three national organizations were within three or four blocks of the auditorium. "I never went to a convention so cheaply" said one member. Rather hard on the taxicab business, but very satisfactory for the pocketbook! How the local arrangements committee managed to have such gorgeous flowers and amusing favors and place cards at various luncheons and dinners will remain a mystery but the effect on the participants may outlive even the spoken word.

And so the stage was set for a program that represented a well-balanced meal. There was something for every taste, and a particularly good diet for the staff nurse whether in private duty, institutional service, or public health. To witness, there was the awarding of the Walter Burns Saunders Memorial Medal at the opening joint session to a

hypothetical private duty nurse for meritorious service in bedside nursing, in which the Private Duty Section of the American Nurses' Association shares the medal with similar sections in all of the states. For the staff nurse in public health, there were a series of successful institutes put on by the National Organization for Public Health Nursing; in fact, so successful that a precedent has been established which calls for repetition! Likewise, the late afternoon series of practical demonstrations—care of cardiac patients, maternity service, tuberculosis clinic, communicable disease nursing—left many wailing outside the walls because they could not get in and created a new demand for future appeasement.

The joint sessions of the three national organizations brought us face to face with many present-day realities. May Kennedy's twenty-point program for the merit system forms a list against which private as well as public agencies may well check their personnel policies. Major Julia C. Stimson's humorous and understanding challenge to the individual nurse to provide for her own security exemplified Miss Stimson's fitness to lead the American Nurses' Association as its new president. As always, Professor C.-E. A. Winslow strengthened our understanding and fired our imaginations, this time, by his address "Organizing for Better Community Nursing Service," in which he pleaded for more consideration of the "consumer" rather than the "producer" if we are to untangle the dual problems of "service" and "payment." Reality was also faced by Ella Hasenjaeger in recognizing the need for and place of the subsidiary worker.

These realities were well balanced with emphasis on the spiritual values in the profession of nursing, the keynote of Effie J. Taylor's scholarly opening address and the subject of the address so brilliantly presented by Rabbi Abba Hillel Silver. Nor were the international aspects of nursing omitted, for Lulu K. Wolf gave a charming review of her own experiences as an American scholar of the Florence Nightingale International Foundation.

The program of the N.O.P.H.N. was excellent, with Dr. Frank G. Boudreau starting us off by finding new places for the public health nurse in the present-day period of transition from disease prevention to health promotion. He sees us more active in nutrition, mental hygiene, housing, and even in helping families to do setting-up exercises for physical fitness! Bradley Buell wants us to take more leadership in community planning, to do more case-finding of family needs, and to keep closer to related social, recreational, and health forces in the community. And imagine the response of the audience to the orthopedist, Dr. Robert McE. Schauffler, who begged us to be more "shrewd observers," to "look out of the heel of the eye." He wants nurses to have opinions, not just to follow orders, and deplores those who are merely "echo nurses." Alas, time permits no more of speeches. We will all look forward to reading them in the magazines.

The business sessions of the N.O.P.H.N. were a model of good organization, brevity, and interest. We were proud of Amelia Grant for her skillful conduct of the meetings and her stimulating review of trends, under the title "Changes and Challenges." Dorothy Deming's general director's report was a masterpiece, not only for its reflection of the wide accomplishments of the past two years and the success of the staff in its many activities, but also for its "streamlining" which made it possible to say so much in such a short space of time! Of special significance is the new vitality and interest of all of the Sections—Industrial Nursing, School Nursing, and Board and Committee Members. We are glad that Miss

Grant was reelected to the Board of Directors, and rejoice, as was so gaily expressed at the concluding meeting with flowers, that we have as our new president, Grace Ross of Detroit.

And last, but by no means least, the membership rally showed that the N.O.P.H.N. knows how to play and to keep up with the times. We are indebted to Mrs. John A. Haskell and the St. Louis nurses for a rollicking skit of "Snow White" as the public health nurse transforming "seven dwarfs" of ill health into physical fitness. So, we sing "Heigh-ho!" to all who made the 1938 Convention a success, and "away to work we go" with new tools of knowledge, a new outlook, and the realization that we gain much when we "all join forces."

# A Board Member's First Biennial

By MRS. THOMAS A. PHILLIPS
Board Member, St. Paul Family Nursing Service, St. Paul, Minnesota

**The thousands of nurses and others who were interested in nursing impressed us with the power they have for educating public opinion**

NO ONE could have listened to, or seen, the fine leaders of these three remarkable nursing associations at their national Biennial Convention without being impressed with the unselfish devotion to their profession that was evident in them all. To an unusual extent, the high tone of the convention was set in the opening talks by the three national presidents and was sustained by the charming and impressive manner in which they presided over the sessions. The speakers in the joint and sectional meetings—both members of the convention and outsiders—were outstanding in their fields, and gave us all a stimulus to go back to our homes with a better understanding of our problems, and a greater desire to do more and better work for our local health programs.

As we drove up to our hotel, our curiosity was aroused as to what the numerous paper bags marked "Mennen" or "Pet Milk" contained. We could see that they were carried by delegates to the convention, as the bearers all proudly displayed badges. Of course our puzzlement will plainly indicate that this was our first attendance at a nursing convention and that we knew nothing of the many displays of professional and nonprofessional articles in the auditorium. We satisfied our curiosities at the first opportunity, and the ones who have families were made more welcome at home because of these interesting and useful samples.

To say that the tea given by the board members of the Kansas City Visiting Nurse Association at the Woman's City Club made us very welcome and aroused our enthusiasm for the rest of our Kansas City stay is putting it very mildly. Our hostesses were so very gracious and hospitable that it is too bad all lay members attending the convention could not have arrived in time for the tea.

What a surprise it was to us to see the immense crowd attending this convention! The thousands of nurses and the others who were interested in nursing impressed us with the great power

they have for educating public opinion. The local and national committees handled the large crowd with ease and dispatch. The registration took a very short time and every meeting ran perfectly on schedule.

It is impossible to remember the sessions at the convention without being made conscious of the beautiful and comfortable auditorium in which they were held. The building was in excellent taste and had comfortable accommodations for all the various sections, despite their different sizes. The dropped hairpins and handkerchiefs observed in every section of the auditorium were evidence that the convention was a woman's affair.

Some of us had such full programs mapped out that we did not have a chance to use the attractive headquarters furnished for the lay members of the National Organization for Public Health Nursing at the President Hotel. It was unfortunate, too, because we felt badly in need of discussing our problems with other board members. Of course, our round-table discussion gave us an opportunity for such discussion, but we felt the need of additional time. The round tables were so stimulating that more time could be allotted to them at the next convention with much benefit to all lay members.

The whole lay program reflects the taste and ability of Evelyn K. Davis, assistant director of the N.O.P.H.N. and secretary of the Board and Committee Members' Section. We appreciate how much time and thought it must have taken to get such a splendid result. Her choice of leaders for the groups was an indication of her discrimination. The leaders at all the lay group meetings gave us many splendid ideas to carry home and inspired us to renewed study and application.

We wish to thank Mrs. Samuel W. Sawyer, President of the Visiting Nurse Association, and her committee for the enjoyable dinner given at the Kansas City Country Club for the lay group. The long drive to the club gave us a chance to see what a beautiful city Kansas City is, and it seemed especially lovely at this time of the year with the irises and tulips in bloom. The first dinner speaker gave us a picture of the federal health program and the part we laymen can take in it. In the second speech, a day in the life of a public health nurse in rural Missouri was graphically pictured by the nurse herself.

There probably was not a "conventionite" there who did not attend an early breakfast or a luncheon or a dinner given by a group from her state, school, or section. These "get-togethers" took place every day in the various hotels.

I wish to thank our Kansas City hostesses in behalf of the lay group for their very gracious hospitality, and to express appreciation to all those responsible for the splendid programs.

**Our next Biennial Convention will be held in Philadelphia, Pennsylvania, in 1940.**

# Family Health—Goal of Public Health

By FRANK G. BOUDREAU, M.D.
Executive Director, Milbank Memorial Fund, New York, New York

**What are the health problems in America today? What are our goals? The writer believes that the future emphasis will shift from disease prevention to the promotion of "abounding health"**

THE PROBLEM of maintaining in sound health the population of this country is so complicated and engrossing that it demands an occasional breathing spell to enable us to view the problem as a whole, and to ensure that our plan of campaign is sound. The population with which we are concerned is changing before our eyes; the birth rate is declining; there are more people over sixty than ever before and there are fewer between one and ten than there were a comparatively few years ago. By and by the population may cease to grow as the rapidly declining birth rate catches up with the more slowly decreasing death rate. Moreover it is impossible for the general death rate to continue forever its present downward trend, and it is quite probable that fairly soon it will begin to rise. These changes need not be regarded as alarming in themselves, although as they become more sharply defined, cries of alarm will arise.

But population changes of even greater significance to our future are also taking place, for certain groups are more fertile than others and are tending to replace them. And as the different groups have varying cultural and hereditary characteristics, these changes in time may transform the character of American civilization. "The best evidence now available," state Lorimer and Osborn, "indicates that the usual negative correlation between fertility and social status involves a gradual decline in average hereditary capacity for intellectual development. . . Such a tendency if continued for many generations would result in a serious lowering of capacity for cultural-intellectual progress by the American people."[1]

Another significant movement in our population is the migration from rural districts to cities. Our cities grow in size largely because of this migration, and the migration takes place because there is the largest surplus of births in our poorest and least privileged rural districts. We take endless precautions with immigrants from foreign countries lest they introduce disease or moral turpitude into this country, but pay little attention to this great stream of internal migration, with all of its potentialities for good or for evil.

These and many other significant changes are taking place in our population, but our task here is to consider how it can be maintained in sound health, rather than to study its dynamics. Let us begin by a glance at the chief health problems in America today.

### DEATHS OF MOTHERS AND BABIES

These are described in the report of the Technical Committee on Medical Care of the Interdepartmental Committee to Coördinate Health and Welfare activities in our Government.[2] Beginning with infancy, we find that 75,000 infants are stillborn, and that of the approximately two million infants born alive every year, 120,000 die before their first year closes. There has been a great reduction in the infant mortality rate in recent years, but practically none

in the death rate under one month, and each year we lose nearly 70,000 infants of this age, more than three quarters of them from causes associated with prenatal life or with the process of being born.

At least 35,000 children are left motherless every year because of the 12,500 women who die from causes directly connected with pregnancy and childbirth, and the 1500 others who being pregnant, die of tuberculosis, chronic nephritis, heart disease, and the like. This picture is made to appear more tragic when we realize that our maternal mortality rate is twice as high as that of Sweden. To what extent is this due to lack of skilled medical and nursing care? In 1936, nearly 250,000 women did not have a physician's care at the delivery of their babies, and 15,000 did not have even the care of a more or less trained midwife but had to depend on neighbors and friends.

We must also remember that there is only one public health nurse for every 5000 persons in cities with more than 10,000 population, and in rural areas there is only one for every 14,000 persons. A larger supply of well trained public health nurses available to these neglected mothers would, I feel sure, prevent a large number of these tragedies. I would mention here in passing the successful experience that has been acquired with the nurse-midwife.

#### DEVASTATING DISEASES

*Tuberculosis* may have fallen from its high estate, but it is still the most important cause of death in adults between 15 and 45 years of age. Some 40,000 persons of these ages die of tuberculosis every year in this country. By applying all our knowledge of tuberculosis prevention we could probably save half of them. We cannot allow this drain on our greatest natural resource to go on when we have the means to stop it. The public health nurse has played a large part in the past in the prevention of tuberculosis. Given a real opportunity she will play a larger part in the future. In describing the tuberculosis problem the Committee noted that home visiting to cases of tuberculosis by public health nurses was inadequate for their proper supervision, and this was the first of the three main reasons given for our failure to make more rapid progress against the disease.

Special attention was paid by the Committee to the prevention of the *venereal diseases*. According to their report, approximately 518,000 new patients with early syphilis seek treatment each year; some 60,000 cases of congenital syphilis occur annually, and syphilitic involvements of the heart and blood vessels and of the nervous system result in nearly 50,000 deaths, in addition to those assigned specifically to syphilis (approximately 12,000). Because of our knowledge of the diagnosis and treatment of syphilis, developed mainly during the last thirty years, no other disease is more susceptible to attack; few other diseases constitute so fruitful a field for public health effort. Here again in the campaign inaugurated so auspiciously by our Surgeon General, Dr. Thomas Parran, the public health nurse will have an increasingly important part to play.

The next problem, *pneumonia*, is one which was hardly mentioned by public health workers a decade ago. Even now, mention of pneumonia brings to mind antipneumococcus serum, rather than a balanced program of prevention. I admit that the serum is probably our most powerful weapon, but there are others of great value. The Committee states that clinic and nursing supervision of infants and preschool children on a community basis are important in the prevention of pneumonia in the ages in which mortality from pneumonia is highest. Attention should also be drawn

to the health supervision of the worker, for pneumonia mortality and disability are excessive among those whose occupations expose them to marked changes in temperature, inclement weather, poor ventilation, and a dusty atmosphere. Nearly 100,000 deaths from pneumonia occur every year, and about 600,000 persons are disabled annually. The disease is most fatal to the extremes of life: infants and preschool children, and persons in late middle and old age.

I have spoken of the aging of our population and would draw your attention to the problems bound up with that process. The expectancy of life at birth increased by 12 years between 1900 and 1935, but no significant increase occurred in the average years of life remaining to persons of middle and advanced age, in spite of the great advances in our knowledge of disease prevention.

As our population continues to age, death rates from the diseases especially severe in middle and old age will continue to rise unless we do something constructive about them. These diseases are mainly: heart disease, nephritis, cancer, and diabetes. Six of the ten days which Americans on the average spend on beds of sickness are due to these chronic diseases. In 1936, cancer was responsible for 10 percent of all deaths, the number being 143,000. Education in the need for early treatment might prevent a certain proportion of these deaths and here the nurse can do her part in rendering family service.

*Diabetes* accounts for 30,000 deaths annually and there are probably half a million persons incapacitated by the disease. Properly supervised insulin therapy has given the most hopeful results. Experience indicates that the death rates can be reduced by as much as 90 percent in young diabetics, and by 37 percent for diabetics over sixty.

The group of diseases affecting the *heart, blood vessels,* and *kidneys* takes an ever increasing toll of lives. In 1936, there were 581,000 deaths from these causes. A large proportion of these deaths represent the final results of the aging process, but many of them are the results of earlier preventable conditions such as childhood diseases, syphilis, and typhoid fever. The problem of rheumatic fever in childhood is a health problem of the first order, affecting one percent of school children in the North.

*Mental disease and deficiency* are health problems of the first magnitude. Half a million persons in this country are in hospitals for mental diseases and 50,000 are on parole; 75,000 persons are in institutions for the feeble-minded and epileptic, and there are an estimated 900,000 mentally deficient belonging to this group outside of institutions. Approximately $150,000,000 of public funds—over one fourth of all governmental costs for health and medical services—are expended annually on the operation and maintenance of institutions for the mentally defective and feeble-minded.

### ACCIDENTS MUST BE REDUCED

The Committee does not mention one problem which I think must concern health officers and nurses. I refer to accidents, particularly automobile accidents. There were nearly 40,000 fatal motor accidents in 1937. The total number of persons killed in accidents of all kinds in 1934 was just over 100,000 persons, giving a rate almost double that of England and Wales, and more than double that of Italy, Denmark, and Belgium.[3] It is said that one third of all accidents occur in the home.[4] Here, then, are two points of attack, the home and the street. I need not speak of the effort to reduce industrial accidents, which is increasingly effective and well organized, and in which nurses in industry have undoubtedly played a part. But I shall have something to say

later on the prevention of accidents by methods which I think will appeal to you as novel and constructive.

In this brief review of present-day health problems I have not attempted to exhaust the list, nor have I touched on all of the conditions mentioned in the Committee's report.

### POSITIVE PROMOTION OF HEALTH

My purpose was to show you one side of the picture of health, the negative side. For there are two sides to public health work: disease prevention and health promotion. We must deal with both simultaneously, and each is closely related to the other. Nevertheless it is important to examine each separately, to ascertain whether we are not devoting too much of our time and attention to one to the detriment of the other. Up to this time the emphasis has been mainly on prevention, while in the future, I believe, it will bear more heavily on health promotion.

Let us examine once more the dynamic population which is our concern. Approximately 3900 are dying every day but more than 128,000,000 are living. We know that on the average every American is disabled by illness for ten days during the year, but if that be true, it is equally true that he must be up and about his work or play for 355 days during the year. What are we doing to promote the health of this great mass of our population, who are well enough to be at work or at play—who are at any rate going about the business of life?

Well, we have tried to safeguard certain parts of their environment. We provide pure water for them, inspect their milk supplies, and try to insure that their meat and food are not harmfully or fraudulently adulterated. We attempt to safeguard the health of some mothers at childbirth and we weigh and measure a few babies and sometimes feed them if they are not prospering. We vaccinate them against smallpox and diphtheria and then when they reach twelve months of age we leave them largely to their own resources until they enter school.

In school some of the children are given superficial medical examinations. In some cases these are followed up, and in still fewer, defects are corrected. The school child is also exposed to a certain amount of health education. When the boy leaves school it is unlikely that he will ever come into direct contact with the public health services again, unless he should happen to contract tuberculosis or syphilis or some other disease with which health agencies are concerned. Count on your fingers the services generally available to the apparently well people in this country. Picture to yourself again the comparatively small fraction of the population that is sick or dying and the vastly larger proportion that is apparently well. Of course, we know that in reality this vastly larger fraction is suffering from defects and disabilities, mental and physical, which prevent it from realizing anything like its full possibilities. Let us then try to imagine, objectively and without prejudice, just what we could do for that population in a program designed to promote sound mental and physical health.

### IS HOUSING A HEALTH PROBLEM?

Well, in the first place, I think we would look to their housing. The possibility of promoting sound mental and vigorous health in the slums of our cities is almost a contradiction in terms. The Chief Medical Officer of the British Ministry of Health has stated emphatically and truly: "Until we can abolish the slum dwelling and the slum dweller, we cannot hope to establish securely the national credit of good health."[5]

But we must not imagine that the only bad housing is that found in large cities; it extends into the smaller cities, into

villages, and even into remote rural districts. We have made little progress in good housing in this country, while in others large fractions of the population have been completely rehoused to their great moral, mental, and physical advantage. Many public health officers see little connection between housing and public health. They agree that each family should be supplied with pure water, good food, and pure air. Sewage and other wastes must of course be safely disposed of. Well, are not all these aspects of good housing? How can there be pure air without ample space and adequate ventilation? How can you have good food without proper means of storing, preserving, and cooking it?

But good housing means vastly more than the sum total of these items. It provides for fundamental physiological needs such as the maintenance of a thermal environment which will avoid undue heat loss, but will permit adequate heat loss from the human body. It allows for sufficient daylight and artificial illumination and the admission of direct sunlight, but avoids glare. It protects against excessive noise and allows for adequate space for exercise and for the children's play.

Good housing also provides for certain fundamental psychological needs, such as adequate privacy, facilities for the maintenance of cleanliness, and arrangements which make possible the performance of household tasks without undue physical or mental fatigue.

Protection against contagion is one of the main features of good housing. Apart from pure water and safe sewage disposal, the exclusion of insects and vermin, and means of keeping milk and food in good condition, there is the question of sufficient space in bedrooms to minimize the danger of contact infection. During the last war, army doctors had to learn anew that the most potent measure against the spread of epidemic meningitis was to reduce the number sleeping in each barrack. Overcrowding, especially in sleeping quarters, favors the spread of this and other epidemic diseases.

Good housing is also a protection against accidents. Thirty percent of all accidents occur in the home, and home accidents account for 45 percent of all injuries from falls, the most important single type of accident. Good housing helps to prevent accidents by sound construction so as to avoid structural collapse, by the reduction of fire and electrical hazards, by protection against gas poisoning, and by measures to prevent falls and other mechanical injuries. But good housing is most important in the prevention of fatal and disabling accidents, when the whole neighborhood is planned to avoid automobile accidents by the proper placing of pedestrian routes so that schools, shops, and playgrounds may be reached without crossing major traffic ways; by planning of residential streets so as to discourage through traffic; by avoidance of blind corners; and by effective screening of playgrounds from automobile ways.

When one considers the amount of time spent in the home, it must be obvious that the house should be so designed as to provide the optimal conditions for work, recreation, rest, and study. We send inspectors into factories to insure that working conditions are not deleterious to health, but millions of housewives work long hours in homes under conditions that cause undue fatigue and not infrequently the breakdown of the most important member of the family.

The American Public Health Association has set up a Committee on the Hygiene of Housing under the chairmanship of Dr. C.-E. A. Winslow, and this Committee has prepared a most valuable report on the principles of healthful housing, which is now in the hands of the principal housing authori-

ties in this country.[6] It may revive your interest in an institution which has so often been said to be dying, to know that the American Committee was a direct outcome of League of Nations' work in this field. I am also proud to tell you that the Milbank Memorial Fund has been the chief support of that Committee from the very beginning.

### NUTRITION THE BASIS OF HEALTH

I believe firmly that an equally important—probably an even more important—means of promoting the health of the great mass of our people would be to insure that they are nourished in accordance with the principles of the modern science of nutrition. We have no other instrument comparable to sound nutrition as a means of aiding men, women, and children to acquire that abounding health which has been the desire of mankind from the beginning of history. Optimal nutrition holds out even greater possibilities than abounding health, for according to Professor Henry C. Sherman and others there is reasonable evidence that it would actually prolong life.

Research in nutrition has shown clearly what elements are necessary in the diet to avoid deficiency disease. The physiological bases of sound nutrition have been described by a number of authorities. A report to which I would draw your special attention is that of a committee of the League of Nations composed of leading nutrition authorities from the several countries, including our own.[7] If the principles of optimal nutrition described in that report were applied throughout the world, it would result in improved health, more social contentment, better conditions in agriculture, improved world trade, more general economic prosperity, and perhaps a more peaceful world.

Dietary records of low wage-earning families show that in our own country the diet falls far short of the desirable standard. Dividing diets into three grades in which grade A represented a good diet, grade B a fair diet, and grade C a poor diet, it was found that in a sample studied one eighth of the population of employed workers' families in the Pacific Coast region were living on C diets; the proportion was one fifth in the North Atlantic cities, and two fifths or 40 percent of white workers in the South. Among colored Southern workers the proportion reached 70 percent.[8]

I am certain that the promotion of sound nutrition is soon to become one of our major public health objectives. I am equally certain that it will call for more and more effort on the part of public health nurses who in their family service are in the most favorable position to influence diets. The peculiarly advantageous position of the public health nurse is due not only to her intimate relation to the family, but particularly to the fact that the families among whom she works are the very elements of our population most in need of the benefits of good nutrition. I am not in a position to say just how the health services of the country will decide to organize the campaign for good nutrition. It may be that more nutritionists will be employed; indeed, I believe that to be inevitable and I am heartily in favor of it. The health services will also need more physicians with specialized knowledge of nutrition to guide and plan their work. In any large health department like that of a state or major city, I think there will come to be a division or bureau of nutrition, directed by a specialized physician and staffed by a number of nutritionists. But the field work will have to be done largely by public health nurses, who will learn more of the science of nutrition than they do at present, and who will find in the health department to which they belong—in the bureau of nutrition—greater opportunity to obtain expert advice.

### MENTAL HYGIENE PROGRAM

Some years ago Dr. C.-E. A. Winslow described the community mental hygiene program[9] as the next great opportunity in public health work. I feel so strongly the truth of this conception that I am adding mental hygiene to housing and sound nutrition as the third of a series of steps which I believe should be taken to promote the health of the great body of our citizens. The report of the Washington Committee to which I have referred described the larger aspects of the problem, and mentioned some of the methods of dealing with it. Dr. Winslow goes into more detail, drawing attention to the mental reactions in society at large which handicap us far more than the financial burden of caring for the violently insane and the feebleminded. These petty fears, doubts, and prejudices, the innumerable subconscious emotional reactions, are as Winslow says, the real obstacles to fruitful living, causing crises between individuals, social classes, and nations. In planning our program of mental hygiene we must first endeavor to ascertain exactly what mental hygiene problems exist in the population at large. Once in possession of the facts we shall be in a position to plan wisely.

Nurses have a particular interest in this subject because almost every family health problem is associated with a mental hygiene problem. Practically no family health problem can be solved without dealing at the same time with the emotional disturbances with which it is associated. If the mental hygiene movement is to be a success, it must be linked up with the health services, and the nurse must have expert advice in dealing with the emotional disturbances of her families. I cannot conceive of any organization of psychiatrists and psychiatric social workers sufficiently far-reaching to cover the field any more than I can conceive of the employment of a sufficient number of nutritionists to give individual family service. But public health nurses will continue to go into the homes, and to meet in the homes with many mental and emotional problems. They will deal with them to much better advantage when there is available to them the expert advice of psychiatrists and psychiatric social workers whose knowledge will thus be made available to a much larger group.

### PHYSICAL FITNESS OUR IDEAL

A recent effort of man to adapt himself to altered conditions of life is the worldwide movement for physical fitness. For we are living in a new and strange environment, to which we have not yet become accustomed. The child spends long hours in the quiet schoolroom—hours when his ancestors played out of doors. Millions are doomed to sedentary occupations. Factory life is far from providing a natural environment for the worker. Preventive medicine is keeping alive millions of individuals who would have perished under the rougher living conditions of our ancestors. The results of this changed way of life are seen in the distorted human body which is far from being the thing of beauty represented by the Greek sculptors. Military leaders have drawn attention to the deteriorated physical status of recruits, a progressively larger proportion of whom do not meet the standard requirements, although in many countries those standards have been lowered periodically.[10]

Something is wrong with our system if in spite of the tremendous advances in our knowledge of public health and preventive medicine we are producing a population of physically weak and unfit individuals. Of course we do not know what is the relationship between physique and health—that is to say we know nothing precise about that relationship. The real trouble lies in our failure to study the normal. And our knowledge of how to keep the indi-

vidual in good health—the positive aspect of our endeavors to prevent specific disease—leaves much to be desired.

During the last few years I have travelled extensively and in my travels I have been struck by the popularity of the movement for physical fitness by physical education.

I was in Czechoslovakia when the Sokols met in Prague and for six hours I sat through a program of gymnastic exercises in which at least a hundred thousand individuals participated, as many as 40,000 at one time. I saw 75,000 members of physical-education societies pass in review through Red Square in Moscow in July 1936, and similar exhibitions were being held all over Soviet Russia on the same day. In 1929 I was a guest of the Governor of Chekiang Province in China at an exhibition of Chinese gymnastics and athletics in which strange contests and exercises were closely scrutinized by a very large audience. In 1937 the British Ministry of Health conducted a nationwide campaign for physical fitness, and this campaign has now extended to the Dominions, notably South Africa. You will find such a movement in every country, and side by side with it a tremendous increase in outdoor games, sports, and athletic activities of all kinds. This worldwide movement testifies to man's hunger for physical fitness, for abounding health, for something much finer and stronger than mere absence of disease. It is my belief that with more precise knowledge concerning physique and health, physical education in the largest sense of the word will become an important instrument in the hands of public health agencies.

I have spoken to you of these subjects because of my belief that we cannot stand still, but must either go forward or fall back.

I have faith that public health nursing will be alive to the importance of new ideas and methods and will so adapt itself to changing conditions and problems that it will continue to be a solid bulwark of public health protection for the socially, medically and economically underprivileged, as well as ultimately for the great mass of our people.

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Presented before the N.O.P.H.N. General Session, Biennial Convention, Kansas City, Missouri, April 26, 1938.

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# Changes and Challenges

By AMELIA GRANT, R.N.
President, National Organization for Public Health Nursing

**Needs and challenges which face public health nursing today are reviewed by the president of the N.O.P.H.N.**

MORE THAN twenty-five years have passed since the National Organization for Public Health Nursing was organized. We will all agree that these have been most eventful and profitable years for our profession. Our duties have changed and expanded as public health knowledge has developed, as the country has expanded, shifted, and changed, and as new opportunities for educational work have been presented. But broadly speaking, our aim today remains what it was twenty-five years ago—to be adequately prepared to render the best kind of nursing and health service to the people.

I do not intend to review the evolution of our work during the last quarter of a century. I do want, however, to touch briefly on a few problems which confront us. First, there is the question of supply of and need for more qualified public health nurses. At present about 18,000 nurses are employed by public health agencies to visit in the homes, to protect the health of school children, to give bedside care and instruction, and to render aid in the clinics. To carry on these functions there should be about 65,000 nurses, or one nurse to each 2000 persons.

Last year Elizabeth G. Fox reminded us that it is time to stop talking about the minimum standard of one nurse for 2000 persons.* The sad fact remains, however, that of the twelve largest cities in the United States not one single city has obtained even this standard. Boston, with 41 nurses per 100,000 population, comes nearest to it, and the median for the twelve cities is only 21 nurses for every 100,000 population.

According to the Report of the Interdepartmental Committee to Coördinate Health and Welfare Activities,** in rural areas the ratio is, on the average, one nurse for every 11,000 persons, and in cities, one nurse for every 5000. In some states, one nurse is supposed to serve as many as 40,000 persons. At least three to four times as many field nurses as are now available in rural areas are needed, and at least twice as many as are available in cities, if satisfactory public health work is to be rendered by the nurses.

### NEED FOR QUALIFIED NURSES

We know that many official and nonofficial health agencies are not now in a financial position to employ the required number of nurses. But even if they had the funds and agreed to add to their staffs the required number of nurses, we are all aware that we could not at this time supply 45,000 additional qualified public health nurses. Our problem, then, is not only the provision of funds, but also the training of personnel. Other professions may be overcrowded; ours is not. Certainly it is not overcrowded

Address of the President, presented at the N.O.P.H.N. Business Meeting, Biennial Convention, Kansas City, Missouri, April 26, 1938.

*Fox, Elizabeth G. "The Past Challenges the Future." PUBLIC HEALTH NURSING, May 1937.

**Interdepartmental Committee to Coördinate Health and Welfare Activities. The Need for a National Health Program. Report of the Technical Committee on Medical Care. Washington, D.C., 1938. Page 30.

from the point of view of need! And it is doubtful whether it is overcrowded with qualified personnel even from the point of view of available opportunities.

This absence of needed personnel is a challenge. The coöperation of our colleges to guide competent young women into the profession should be secured. The National Organization for Public Health Nursing should continue to work with the National League of Nursing Education to place more emphasis on the health aspects of nursing in the undergraduate curriculum. Public health nursing organizations should be encouraged and helped to provide adequate practice fields for undergraduate and postgraduate students. Those directing public health services and those preparing nurses for the various fields of activity should work closely together.

#### PREPARATION FOR SPECIAL FIELDS

The second challenge before us is to prepare nurses for new and special fields, such as syphilis control, care of crippled children, and maternity and child hygiene services. The place of the nurse in these fields should be defined, and carefully planned preparatory courses offered. Not only young women entering public health nursing, but those already in the field with good experience in general public health nursing should be helped to understand their opportunities in these fields. The social security stipends are practical means of accomplishing this. I note that last year, there were 995 trainees receiving such help.

Theoretical courses are more readily available than suitable practical experience. Agencies having well organized programs in these special fields have a heavy demand for the use of their field-work facilities, and it is to be hoped that they can make generous opportunities for the training of those who must carry on like services in other communities whose work is not as yet so well developed.

Adequate supervision and sound staff education which stimulate thinking and promote growth are needed in every well set up public health nursing service.

#### PREPARATION FOR TEACHING

A third point for consideration is the question of preparing nurses for teaching. We say—in fact, we know—that a primary function of the nurse is to teach, to bring the scientific knowledge concerning health and better ways of living to all the citizens, in such a way that they not only understand what to do, but are motivated to change habits and behavior. The preparation of a teacher requires long and systematic training. Are nurses expected to acquire the same skill in this phase of their work as they are expected to have in other techniques and procedures of nursing? Can this phase of nursing education be more carefully planned in both theoretical and practical work? Do our postgraduate courses give as much attention to methods of teaching as to content or information? Are staff-education programs including methods of teaching as much as is desirable, in view of the large and important place which teaching has in the nurse's everyday service?

No teacher has a more diversified or more difficult class than the public health nurse—all age-groups, with varying economic, social, and educational backgrounds, and with racial and national traditions and habits sometimes well fixed. To be sure, the nurse has a very easy approach. Her subject is one of universal interest, and she meets individuals and families as a friend in whom they have confidence and who renders an appreciated service. These factors are, of course, decided advantages. But to teach so that people actually change behavior, so that they do not just know what to do, but why they do it, is a reasonably high standard by which to measure success in any field of teaching. The public health nurse needs much help with this phase of her work in un-

dergraduate and postgraduate schools, and through staff education.

### THE NONOFFICIAL AGENCY

Fourth, I think that at this time, with the trend towards public health nursing under official guidance, it is essential that the public be constantly informed regarding the advantages of the nonofficial public health nursing agency. We know that the private agency supplements the work of the official agency, and that it often serves as a practice field for educational and experimental activities which the official body is not always in a position to do. But nowadays the public seem to think that everything is going to be run by the government. In 1937 nearly 67 percent of all public health nurses—exclusive of those engaged in industries and nurses in departments of colleges—were employed by official agencies, and 33 percent by nonofficial organizations. Between 1931 and 1937 the number of nurses employed by official agencies increased by 21 percent and the number of those serving nonofficial groups decreased by 6 percent.* We are all delighted with the splendid impetus given to public health nursing by the Social Security Act, but we must find ways and means to make the public realize that the volunteer public health nursing organizations occupy an essential position in the structure of this country's public health program.

### NEEDS FOR STUDIES

Fifth, we are challenged by the fact that there is an absence of scientific studies to throw light on our problems. We need, for example, an analysis of the place of the public health nurse in the school health program; a study of how the generalized nursing plan is working in various parts of the country; a reexamination of the reasons why one public health nurse per 2000 population is not enough; an inquiry into the extent to which official agencies in large cities should take on bedside care, and if not why not; a study of the relation between nurse, social worker, mental hygienist, and nutritionist in a public health agency of a metropolitan area, an urban community, or a rural community.

### INTERPRETATION OF N.O.P.H.N.

Sixth, it is essential that we devise ways and means by which a larger part of the public is kept informed on the work and problems of the N.O.P.H.N. There are at least two good reasons for this interpretation of our service to the public. In the first place it is necessary in order to make possible a wider, more effective use of the Organization; second, it is needed in order to bring about a more secure and adequate financing so as to make the work of the Organization sufficiently extensive and thorough to provide the needed services.

The N.O.P.H.N. is proud that through memberships the largest part of its budget is provided. But it also needs contributions which are made because more people know our work and believe that public health nursing of a high quality is an important factor in every public health program.

. . . . . .

It is for the purpose of meeting these many challenges that the National Organization for Public Health Nursing exists. It has a responsibility to make studies on various phases of public health nursing, to promote higher professional standards, to assist public health agencies with administrative problems, to serve as a counselor and guide to public health nurses in the country. We have a good magazine; we have produced some excellent literature and handbooks for guidance in our work; we have conducted major fact-finding studies. And we should all be challenged by the fact that so much more remains to be done.

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# The Nurse as a Family Teacher

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**How can our educational work with the family be made more effective? A preliminary discussion of a study which has far-reaching implications for health teaching**

IT IS HARDLY necessary to summon arguments in support of the statement that the public health nurse should be a teacher as well as a nurse. To teach, according to the dictionary, is to make aware of. And the public health nurse who fails to make her families aware of health and the paths to health must surely be little more than an automaton, who performs some services, to be sure, but leaves her charges none the wiser.

It is not only the educators who put the nurses in the ranks of the teachers. The National Organization for Public Health Nursing in the reports of its survey of public health nursing conducted in 1931 and 1932 makes the point that departments of health, departments of education, and public health nursing associations emphasize the teaching aspect of the nurse's work.** Yet the same survey found that in actual practice the average home visit had little educational value. The nurses' performance appeared at its lowest level in what, ideally, should have been one of their most important services.

Accordingly, about a year ago, the Public Health Service undertook an analysis of the educational work of public health nurses, in the hope of discovering some way by which it might become more effective. The objects of the study were to determine, as far as possible, the virtues and failings of the nurses' educational efforts, and on the basis of the findings, to make recommendations which might lead to higher achievement.

The data are verbatim transcripts of nursing visits in the home. The stenographic notes were taken by experienced workers who accompanied nurses on their routine home visits. A detailed description of the method and a critique of its value and limitations will appear in future issues of the *Public Health Reports*.

The study has not yet progressed to the stage where definite results can be shown and conclusions presented. However, a preliminary study of the material now available, viewed in the light of our knowledge of the way in which learning takes place, indicates that certain general educational principles are readily applicable to the teaching of nurses.

## INTEREST—A FACTOR IN LEARNING

Probably the most important factor in a learning situation is the interest which the learner may have in the material to be learned. Thorndike found in his investigations that "learning without interest of some sort does not occur to any appreciable degree."*** If the families whom a nurse is trying to teach are indifferent to what she tells them,

*From the Division of Public Health Methods, National Institute of Health.

**National Organization for Public Health Nursing. Survey of Public Health Nursing. The Commonwealth Fund, New York, 1934.

***Thorndike, E. L. Adult Interests. The Macmillan Company, New York, 1936. Page 47.

it is not very likely that she will be able to alter their health behavior to any great extent.

But it may be argued that everyone is interested in health. This is only partially true. Few well people are willing to do anything out of the ordinary to conserve their health; the sick are the ones to whom health is of paramount interest. An individual who is ill invites the physician and nurse to visit him and asks for their advice and assistance. He is uncomfortable, and in his eagerness to feel well once more he will for the most part rely on their instructions. If he is told to submit to an unpleasant treatment or observe a rigid routine, he will follow the more or less dictatorial orders of the physician and nurse. He seldom demands an explanation for things he is told to do and even less frequently is given one. He does what he is advised because he is interested in the outcome—recovery of his health.

But the well individual, and frequently the ambulatory patient, feels that his state of being is satisfactory. He is seldom interested in inconveniencing himself in order to follow a health practice advocated by public health workers.

The following reasons given by mothers for not attending child welfare clinics illustrate apathetic attitudes and will have a familiar ring to all public health nurses:

NURSE: You haven't had him in to the health station.

MOTHER: He's getting along all right, and we didn't think it necessary.

. . . . . .

NURSE: You haven't had Barbara into the clinic since June, and June is such a long time.

MOTHER: Yes, it is, but she is getting along nicely.

Such conversations as these could be repeated many times from our data, not only with child welfare cases, but also with school children, venereal disease patients, and contacts to tuberculous patients.

Because of this lack of interest in hygienic habits on the part of the individual who is not sick, the task of raising his standard of health conduct is a difficult one. We cannot say to him as we do to the sick man, "You must do this," or "You should do that." To be of value, our teaching must be motivated in such a way that it will induce an active rather than a passive response.

Frequently nurses whose work we studied assumed that the patient's interest in preventing diphtheria, stamping out syphilis, or controlling tuberculosis was as great as their own. It would be fine if this were true, but we all know that it is not. Note the following verbatim extract from a nursing visit to secure reëxamination of tuberculosis contacts:

NURSE: Did George and Ruth go back to the clinic?

MOTHER: No, they didn't go.

NURSE: How about Ruth? Is she still working?

MOTHER: Yes. She said she doesn't want to go back to the clinic. She said she doesn't want to know how she is getting along.

NURSE: I know, but she would much rather find out in time. She could go on Thursday night at 7:30. She hasn't had an x-ray for some time.

And from a child hygiene visit:

NURSE: Has the baby had the needles for diphtheria?

MOTHER: No, she didn't get the needles.

NURSE: They should have these things done. As they get older and go out in the street and come in contact with other children, it's best that they should have these things. Do you give the baby codliver oil?

MOTHER: Yes.

NURSE: And her eggs?

MOTHER: I give her eggs, but not often; spinach and carrots and baked potato. But I didn't change her milk.

NURSE: Then you should bring her in, because she should have that changed, and the

baby weighed. When they give the needles, they will give you a card. You should keep that because when she goes to school they will ask about it.

The mothers in these two cases have probably been animated by as lively an interest in correct health practices as the average ten-year-old boy has in compound fractions when his teacher tells him to learn about them because she tells him to.

This overemphasis on the accomplishment of a definite objective without consideration for the patient's interest, or without permitting him to feel that he has any initiative in the matter, too often approaches a kind of police work. Unquestionably, the objectives have their own importance and the nurse properly considers them her job. But she has another job, too, and brusque insistence on administrative and technical details may rob her forever of opportunities to be of educational service. For example, the following conversation took place in a child hygiene visit:

NURSE: Do you take the little boy in to the child hygiene clinic?

MOTHER: Yes.

NURSE: He was vaccinated and got his protection for diphtheria?

MOTHER: No, he never got his vaccination.

NURSE: You should take him up there, too. Of course he has to have these things before he starts school, so it's much better that you get them now Do you feed the baby regularly?

MOTHER: Yes.

NURSE: You take the little boy up so you can get him vaccinated and get his protection for diphtheria, and when he starts to school, all that will be done, and you won't have to bother with it. And you take this one up there regularly.

MOTHER: All right.

NURSE: How are you getting along with the baby, all right? What about his formula? You make all the formula up at once?

MOTHER: Yes.

NURSE: All right, then you take the baby in and we won't bother you. If you don't take it in, we'll have to come back.

And on a tuberculosis follow-up visit, the conversation was:

NURSE: How long has it been since your husband died?

MRS. JONES: The end of May.

NURSE: The clinic nurse told you for two years you would have to be checked up, and Phyllis, too.

MRS. JONES: After the death?

NURSE: Yes, two years after. So when they give you a date, you should come back.

In contrast note the following, where the objectives of the visits are almost identical with the examples above:

NURSE: She will soon be six months old, and you will soon be thinking about getting the toxoid for her. It is the treatment that is given to children to prevent them from getting diphtheria. Have you heard of toxoid?

MOTHER: Toxin-antitoxin shots? I had them when I was a child.

NURSE: We advise you to have that when the baby is nine months old. It is to prevent the baby from getting diphtheria. You know diphtheria is a serious disease for young children.

. . . . . .

NURSE: Has Ellen had an examination since you knew you had tuberculosis?

MRS. SMITH: Oh, no. She's fat. She's healthy.

NURSE: But just the same, she was exposed and really should be examined. Tuberculosis is a contagious disease; you catch it from being around people who have it. So any person who has been in contact with anybody who has had tuberculosis should be examined. The doctor will give her a tuberculin test. That is to show whether the tuberculosis germs have entered into her body, and if it shows positive they take an x-ray to find out if there is any damage to her lungs. We often find children with positive tests, which shows that they have germs in their system. Then the doctor takes an x-ray to find out if these germs have done damage to the lungs. That is a very good thing for children, don't you think?

MRS. SMITH: Sure, it is good.

NURSE: Everyone who has been exposed to the disease should have an examination. They may look all right, and feel all right. When the disease begins, she might not even know it. The way it starts sometimes, there is no cough, no pain or any other way you

can recognize it. Some people with it are overweight. Wouldn't you like for her to be examined, to be sure?

These latter visits, in addition to being less dictatorial, are excellent illustrations of the way in which health teaching may be motivated. They present information concerning the importance of diphtheria immunization and the reasons for examining those who are contacts of tuberculosis patients. By having the facts before them, the families are able to recognize the importance of the advised actions. This is by no means a novel idea, but in our study we found it a frequent failing of the nurse to insist dogmatically upon a specific course of action without offering the family any explanation of its value. Long ago we abandoned learning by rote in our schools; it is time we discard it in public health education as well.

### TEACHING BY EXAMPLE

Another factor that may handicap the nurses in presenting convincing arguments for the health behaviors they advocate is the negligence of public health personnel in following these practices themselves. Recently we made a survey of the health practices of about 800 public health workers, among whom were 234 nurses.* It was found that a fourth of the children of public health workers were not protected by immunization against smallpox and diphtheria. Although the nurses scored considerably better than the other public health personnel, 10 percent of the nurses' children between the ages of one and fifteen had not been given these two protective measures.

A fifth of the nurses had not had a Wassermann test; and of those who were married, a third had not persuaded their husbands to have this test. Still further, only 20 percent of the nurses who had had a Wassermann test had specifically requested it. They had the test because it was either routine or required in connection with their work. Is it surprising that we experience difficulty in convincing others of the need for specific health practices when we are so negligent ourselves? Is it possible that we are not really convinced of the value of the practices? If this is true, we should not urge them on others; if we are convinced we should be the first to follow them.

*Unpublished material gathered by the Division of Public Health Methods, U. S. Public Health Service, Washington, D.C.

### "I WOULD LIKE YOU TO DO THIS"

A method of motivation used extensively by many of the nurses is to ask the patient to coöperate with the nurse or health department in the achievement of some objective. It is illustrated in the following verbatim extracts:

NURSE: *The health department* is very anxious that the mothers bring the babies to the child health center.

NURSE: *I* would like for Carleton to be examined because I think he is run down.

NURSE: *We* would like for you to come to have the Schick Test for Harry. Then the same day we could have the baby immunized and then we ask you to come back with him in six months to have the Schick Test. The Schick Test is the only way *we* have of knowing whether the work *we* wish was done.

From these conversations, it would appear that the child is to be brought to the clinic to satisfy some vague aim of the nurse or health department, and that the parent's interests are not involved. The nurse is imposing her own objectives upon the mother as sufficient motivation, disregarding the obvious and almost certain appeal to the mother's interest in the welfare of her baby.

There are, of course, many mothers who do not feel that they need any instructions from the nurse and consequently are not too receptive when a nurse calls and

begins to outline the routines for taking care of the baby or the hygiene of pregnancy. Some nurses handle such a situation effectively by describing the services of the health department or public health nursing organization. It would be excellent if more would follow their example. Here is a case in point.

NURSE: I'm from the X— organization. May I come in?

MRS. BROWN: Sit down.

NURSE: I am coming to tell you of the services we offer to those who are expecting babies. The names of all the patients that come to the hospital prenatal clinic are referred to us and we make a home call to invite the mothers to mothers' club. We instruct the mothers in matters pertaining to the baby before and after it's born. We help the mothers with any problems they may have about clothing and diet and their own care, and all that. You see, at the hospital clinic they don't have time to teach the mothers care of themselves. Any little problem whatever that comes up that you don't understand—you come to mothers' club and bring it up, and they will try to explain it to you to the best of their ability. They will show you how to make the baby's clothes if you are interested in making the clothes.

MRS. BROWN: That's very nice.

### MEETING A NEED

Another means of arousing people's interest in health practices and securing their coöperation is the rendering of real service in time of need. This method is most successful in organizations which maintain a bedside nursing service. Unfortunately, in many official agencies it is a policy not to render bedside care. Note the following situation where the nurse making a visit to a tuberculosis patient found her in bed.

NURSE: Have you been able to get back to the clinic?

MRS. GREEN: No, I was planning to go today but I feel too sick.

NURSE: Did you call a doctor in?

MRS. GREEN: Yes. He told me to stay in bed.

NURSE: Well, I am so sorry. I am not going to talk to you much this morning, so I won't advise you about going into the clinic since he has ordered you to stay in bed. I will report you in bed. Has a visiting nurse been in to see you?

MRS. GREEN: No.

NURSE: If you do think you need a nurse *be sure to get in touch with the visiting nurse.*

What attitudes are created in patients by such a restriction on the activities of a nurse? It is easy to imagine the patient recounting the incident to her family and neighbors, concluding with a sniff and some variation on the "Them-that-can-does; them-that-can't-talks" theme. The prestige of the nurse is reduced along with her chances for successful health teaching. Under the best circumstances, the patient is likely to feel that the nurse offers to help only when there is nothing to do, or possibly, that she is not capable of giving any real service.

The nurse has no choice but to follow instructions when the policy of the local health department does not permit her to give care to the sick. Nevertheless, it is often found to be a real handicap to her in her relationship with her patients.

### MISUSE OF RECORD KEEPING

We find, too, a strange fixation among public health workers in connection with record keeping, which frequently gives rise to unnecessary difficulties. Sometimes it is the fault of the administration, sometimes of the nurse. Too often, securing information for a record card becomes an end in itself and is forgotten as a means to a desirable end. Undoubtedly records have their uses, but a patient must be puzzled and resentful when he is ordered to tell the health department about his citizenship, his parents, where he has lived, what he does, and how much money he makes, in order to learn that he should drink milk and eat vegetables, see a doctor, or go to a clinic where he will probably be asked the same set of questions over again. It would be interesting to know how

much of this information is ever referred to for any reason whatever.

In a case such as the following, the patient can't fail to feel that he, as an individual, is of little moment as compared to the nurse's interest in the purely mechanical processes of her job.

NURSE: (bluntly): Are you married or single?

MR. GRAY: Married.

NURSE: Where were you born, Mr. Gray?

MR. GRAY: Scotland.

NURSE: How long have you been in the United States?

MR. GRAY: Twelve years.

NURSE: Have you citizenship papers?

MR. GRAY: Yes. Oh, I have answered those questions a thousand times.

NURSE: Well every organization has its own set of questions to ask.

Or, on a first visit to a tuberculosis family:

NURSE: How old is Walter? Is he 30 years old?

MRS. PENN: He is 30.

NURSE: He is single, isn't he?

MRS. PENN: Yes.

NURSE: Where was he born? In the United States?

MRS. PENN: No, he was born in Austria.

NURSE: Is he a citizen?

MRS. PENN: Yes.

NURSE: What is his occupation? (Answers are omitted from here on.) How many rooms do you have? How many living in the household? Your first name? The father's name? How old are you? And the father? You are a housewife?

MRS. PENN: Yes. Is this catching?

NURSE: Yes, if you come in contact with it, yes.

MRS. PENN: Well, what can we do?

NURSE: What does the father do?

MRS. PENN: Basket maker. So what can we do?

NURSE: Just a minute. I will tell you all about that. Your address before this?

This conversation is not only an illustration of placing too much emphasis on records, but of the failure to take advantage of an expressed interest of the patient.

### ADAPTATION TO NEEDS OF LEARNER

One principle of teaching which is particularly important to the nurse as a family teacher is: Instruction should be adapted to the individual's symbolic level. In other words, instruction must be given in language easily understood by the patient, and wherever possible, delivered piecemeal, in bits adapted to his ability to retain it. This is a more exacting requirement than is generally recognized. The educational and mental equipment of different people varies widely. Ordinarily opportunities for frequent repetitions are limited, and consequently, information must be given in a form readily comprehensible.

Our study has indicated that nurses do attempt to adapt their vocabulary to the patient's mental level. In developing a short method of determining the relative time a nurse devotes to teaching during a visit, we found that, on an average, her conversation was conducted in four-letter words.

Nevertheless, it is difficult not to slip occasionally into familiar technical language which is meaningless to the patient. Observe these cases:

NURSE: (Asking about two children in a tuberculosis sanatorium) Are they active cases?

MRS. FIELDS: What does that mean? Does that mean whether they are getting worse or better?

NURSE: It means are they positive?

MRS. FIELDS: I don't know. They have spots.

The nurse's next statement was: You have no other children?

. . . . . .

NURSE: (On a tuberculosis follow-up visit) We wouldn't be coming if he were an arrested case. When he is an arrested case we won't come at all.

MRS. NEAL: Restification—what is that?

During a follow-up visit for syphilis, this was the conversation:

MRS. FOX: The nurse claims the dose was too strong. She came out to see why I stopped treatment, but I never went back. My arm would swell.

NURSE: She was explaining to you that the doctor had to have the reactionary measure to know the physiological effect on your body, and the next dosage he would give accordingly.

MRS. FOX: My husband told me I would get along all right now, and I don't want to take any more.

NURSE: Well, I think with a history like yours the doctor would advise you if it was still imperative that you have that dosage according to the degree of involvement. If it were necessary to give the same dosage, then it would be necessary for you to have bedside treatment until that wore off. Even then that would be better than neglecting so serious an affair as that.

If you have ever asked an economist about the monetary situation and had him reply in a swift flow of technical financial terms, or even had your automobile mechanic explain in detail what is wrong with your transmission or carburetor, you know how confusing the jargon of another field can be. Our own terminology is so familiar to us that it is often difficult to recognize it as meaningless to others.

Apparently failure to adapt advice to the patient's background occurred most commonly in giving general instructions such as "Eat lots of nourishing foods," or "Take plenty of rest," or "You must observe the precautions,"—when the patient did not know what are the "nourishing foods," how much is "plenty of rest," or what are the "precautions" for a tuberculous patient to follow. So long as the patient remains in ignorance of the implied details of such terms, he cannot change his behavior to comply with the instructions.

In contrast, some of the nurses planned menus with their patients, and coöperatively worked out with them schedules of rest, sleep, exercise, and eating. It is recognized that good nursing practice has prescribed this method of teaching for some time; yet many of the nurses in our study gave very general advice which was totally inadequate as a guide for the patients.

Although our study will not permit an evaluation of how much instruction at any one period of teaching a patient can remember, we question whether a patient is able to recall all that a nurse teaches her when the period of teaching covers as much as an hour or more. Some of the nurses spent as much as an hour and a half on prenatal and infant hygiene visits. During that time they covered almost all the material on the hygiene of pregnancy or the care of the infant.

For example, on one visit the nurse taught rather fully concerning the following items: The desirability of medical care during pregnancy, how it could be obtained, and what the doctor would do for the patient; the value of immunization for the three children; the meaning of urinalysis, including an explanation of each step in the process; the arrangements for home delivery, including discussion of supplies, methods of securing certain items, making of pads, set-up of toilet tray, and calling a physician for delivery; diet of the patient and family, including a discussion of the values of canned milk and the way to use it; dental care; clothing for the mother and baby—their type and how to utilize substitutes; exercise, rest, elimination, drinking of water, symptoms of toxemia, and adjustment of expenditures to budget allowance. One wonders how many of the details the patient was able to recall and put into effect.

### SUMMARIZING THE VISIT

The possibility of the patient not remembering instructions suggests another teaching aid that was used very frequently by the nurses. Since repetition is one of the factors that bring about learning, the practice of summarizing at the close of the visit the im-

portant items taught the patient helps to fix them firmly in his mind. This technique is essential when the nurse has been obliged to teach many things during the same visit. Here is a sample summary of a visit that was made by one of the nurses:

NURSE: All right, Mrs. Hill, I think that about finishes our message to you today about little Sally and the baby. Let's go over what we have had. Little Sally, between now and the next time I see her: We're going to take care of those lovely teeth and try some recipes for liver. And our little baby: We're going to come up and see about three-hour feedings instead of the four-hour feedings because you think your milk supply is decreasing. And in the meantime you're going to try to get more milk for yourself and ask the doctor about the cereals. Is there any question you want to ask me?

In addition to a verbal summary of the visit, we venture to suggest a written summary, which would be given to the patient. This procedure was not found in any of the visits we have studied thus far. Yet those of us who attend classes practically always take notes of one kind or another. Of course the patient seldom makes the notes, even though it might be desirable for her to do so; consequently it becomes the job of the nurse. The only written material that any of the nurses left with the patient was information about a physician, clinic, or social agency to which the patient could apply.

A written summary properly executed would serve two important purposes. It would remind the patient of the things that the nurse had taught, and keep him aware of the things he was supposed to do. It would also help the nurse to check for herself the material she had taught. If the nurse used carbon paper and the summary were made out in duplicate, it could serve as the nurse's record of a visit to the family, thus permitting the nurse at subsequent visits to review what she had previously taught and continue her teaching at the point where she had left off. By revising present methods of recording in the home so that these carbon copies could serve as a nurse's report of the visit, the job of record-keeping would be automatically solved. Whether or not such a procedure would be effective cannot be stated without experimental trial. We hope that some of you will evaluate it.

Finally, there are certain administrative procedures that limit the effectiveness of the nurse as a family teacher. All of these are factors over which she has no direct control. Two of them are mentioned here in the hope that administrators may make such changes as are necessary to remove these handicaps to good teaching.

The first of these factors is the lack of coördination between clinics and field service. In a well organized service the nurse presumably coördinates her teaching in the home with the findings in the clinic. To do this there must be some administrative machinery by which the field nurse is informed of the findings in the clinic. Consider the following example:

NURSE: Have you been in the clinic lately? (The nurse should have been notified so she wouldn't have had to ask.)

MRS. WOOD: I went a week ago yesterday.

NURSE: A week ago yesterday? Did you take a specimen of your urine?

MRS. WOOD: Oh yes.

NURSE: Did he think you were getting along all right?

MRS. WOOD: Yes. . . .

NURSE: We would like for you to drink eight glasses of water a day. It shouldn't be so hard to do that, now that it is hot.

MRS. WOOD: The doctor told me to stop drinking so much water because my feet swell.

The nurse's standing orders for instruction were contraindicated when the patient was examined at the prenatal clinic. Yet the nurse had no means of knowing what the physician had found. Such situations tear down the patient's confidence in the advice given her either

by the doctor or by the nurse and sometimes both. Unfortunately, such lack of coördination exists all too frequently.

A second way in which the effectiveness of the nurse's teaching is hindered by factors outside her control is the failure of the clinics to deliver the type of service she describes. When patients attend clinics at the suggestion of the nurse and find it to be an unpleasant experience, they are less inclined to listen to the nurse's advice on other problems. Consider the following in an infant-hygiene visit:

> MRS. BROOKS: The only thing I am worried about him is that his navel extends out a little. You see, I thought it was a navel rupture, so I went over to the doctor as you told me to do. He didn't say anything at all about the child's navel, so I asked him about the baby's navel. So he said, "I think it's a little ruptured." I said, "Well, will you tell me for sure," and he said, "I think it is, don't worry about it," but he never examined the baby's navel at all. *That's one reason why I didn't go back.*

Another mother of an infant with excoriated buttocks stated:

> I went to all the trouble of taking her to the clinic. That woman doctor just said "Hello," and "Goodbye." She didn't say a word about the baby's buttocks or anything.

There are other administrative procedures that interfere with the effectiveness of the nurse as a family teacher. These are, however, sufficient to illustrate that field nursing cannot succeed without adequate coördination with all the other efforts of public health workers.

## SUMMARY

Teaching is like selling. Just as one cannot say that he has made a sale until someone has bought, neither can we say we have taught until someone has learned.

Interest in the thing being taught is a prerequisite of learning. Therefore all health teaching of the nurse must consider the patient's interest and build on that. Some of the methods of stimulating interest as revealed by our study are:

1. Informing the patient concerning the reasons for the health practices he should follow rather than telling him the things he must do.
2. Describing the services which the patient is entitled to if he wishes to use them.
3. Rendering to the patient a service that he actually needs.

Some of the procedures that tend to antagonize are:

1. Ordering the patient to perform a health practice because he has to do it anyway since it is the health department regulation.
2. Failing to render a service when such is needed.
3. Asking many questions to fill out a record.
4. Failure to make the objective of the teaching something the patient wants to do for his own satisfaction.

To be successful in our teaching we must practice what we preach. Or, stated medically, we must not prescribe medicine we would not take under similar circumstances.

Another essential factor of effective teaching is the adaptation of the material to the limitations of the learner. This includes teaching in terms familiar to the public, not giving more material than can be remembered, summarizing at the close of the teaching period, and perhaps giving to the patient a written summary of the teaching.

None of these suggestions will yield maximum results if they are followed without consideration of the human side of the job. In our work, we must remember that the attitudes which are instilled in the patient through all of his contacts with public health workers determine whether or not our teaching will be effective.

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Presented before the N.O.P.H.N. General Session, Biennial Convention, Kansas City, Missouri, April 26, 1938.

# The Nurse's Responsibility for Her Own Security

By JULIA C. STIMSON, R.N.
President, American Nurses' Association*

**To provide for her own security, a nurse must not only consider the factors in her personality which make for insecurity in employment but she must "own her own life"**

MANY OF US remember the days when, in addition to our alumnæ dues, we were asked or obliged to make contributions to the Relief Fund, which, we were told, would be sent to Headquarters of the American Nurses' Association. This fund was for the assistance of disabled members of the Association.

The plan had existed for many years. Although the funds on hand at Headquarters were large, the income, only, was available for beneficiaries, and the number of applicants for relief was increasingly out of all proportion to the increase of the money available. Such a situation, of course, meant ultimate financial disaster. The actual case work for beneficiaries was entirely unsatisfactory. Even the state relief committees were unable to make the personal contacts and give the social treatments necessary. The impossibility of doing social case work by correspondence became more and more evident.

When the problems of relief-giving on a national basis were first seriously studied,[1] there were 175 beneficiaries, half of them with tuberculosis, more than half of them thirty-five years of age or younger. The average amount received by beneficiaries was $15 a month. More than a quarter of the time of the Headquarters staff was required to care for the affairs of the fund. The membership of the American Nurses' Association at that time was 88,000.

So many questions had been presenting themselves regarding this inadequate relief—eligibility, qualifications, duration, supervision and control, administration at Headquarters, and the unsatisfactory long-range value of the help given—that finally after many conferences and much advice, it was voted in 1932 to discontinue relief-giving on a national basis, and the return to the states of the funds on hand was commenced.

### PROVISION FOR THE FUTURE

The discussion of relief led logically to that of insurance and pension—in other words, to making provision for one's self. Times and thinking have been changing and relief as far as members of professional groups is concerned has become a term that has been transformed into self-help, long-time planning, and thrift. This new concept has developed as new opportunities and constructive plans have evolved. No longer [illegible] self-respecting business women—and all women who earn their living are business women whether it is in professional work or not—think in terms of possible relief for the time when they can no

*Major Stimson was elected President of the American Nurses' Association for the biennium 1938-1940.

longer care for themselves. It is true that in the old days of the Relief Fund few young nurses consciously thought of the fund as a possible refuge in time of need, for few young nurses give thought at all to the chance of sickness or unemployment. Their minds are full of the new joy of earning, and the possibility of marriage. Retirement and old age seem very remote contingencies. Nowadays, however, wise instructors in high schools, colleges, and professional institutions are urging the attention of young people to definite programs which, whether they are married or unmarried, sick or well, will give a measure of safety and security as the years come on.

With the increasing number of women in industry and the professions, the old fantasy that women work for pin money and not because they have to, is disappearing, and studies show how large a proportion of working women are supporting others besides themselves. The business woman nowadays is taken for granted. However, a grave menace to the success of both men and women who work is looming larger and larger and is receiving more and more attention.

### HOW OLD IS OLD?

This menace is age, inexorable, uncontrollable, like the tides of the sea, the change of the seasons. A recent article in *The New York Times* says:

> Middle age is economic old age . . . Even if we had no depression, the general conviction that age, next to occupation, is the most important factor in a worker's life is reinforced by the findings of official investigations made in New York, Massachusetts, California, and Maryland, and by studies of special industries.[2]

While many of these studies are about men, I can give you some statements about women that will probably amaze you. They have a bearing on our own problems and should be a hammer to help drive home our own individual responsibility for our future security.

The New York Commissioner of Labor Statistics in 1900 set the deadline for women at forty-five years of age and for men at fifty.[3] This limit for general unemployability was made thirty-eight years ago, but what about now? Recent reports of eleven public and eleven private agencies in twenty widely scattered cities in the United States indicate that applicants of forty are usually classified as "older women."[4] The dividing line is sometimes even less. Others say that women reach the so-called "older" status at about thirty-five years. Moreover, since it is becoming increasingly hard to place applicants over thirty, it has been said that that age—thirty—might be called the dividing line between "older" and "younger" women.

Are nurses different from other women in the factors that sometimes all-too-rapidly do more than the mere passing of years to bring on old age? Everyone knows that old age is a relative matter, a state of mind, and it is significant to note that employment bureau directors say that in an enormous number of cases the older woman is not hampered so much by her age as by her attitude and the fact that she is inflexible.[5] Lack of alertness, loss of an aggressive youthful spirit and enthusiasm, poor health, carelessness in dress and appearance, touchiness and other emotional attitudes, lack of a sense of humor, sad looks, carrying grouches and jealousies—all these and similar sins, employers say, are the causes of putting women into the "older woman" group. These are depressing statements, but they are useful. I could, I am sure, thrust you into a deep gloom if I presented to you even a portion of the facts I have been reading recently about the problems of the older woman. Since I have had the subject of this paper in mind, statements having a bearing on it have jumped to my eyes from nearly every paper or magazine or report that has come to my attention.

There are, however, hopeful aspects

and it is those that I want to put before you next, as well as to make you believe with me that all these facts about women in the business life in general are equally applicable to nurses.

### MENTAL ATTITUDE

There is much unemployment among nurses. There are employed nurses who are discouraged and dissatisfied. Promotions have not come along as fast as they think they should. They are growing unhappy and slowly a spirit of unrest moves in. It is said that few people fail because of poor intelligence or lack of ability to perform a given task successfully, but they fail because of their inability to use properly such aptitudes and abilities as they possess. Mental attitude is the most outstanding cause of work failure, psychiatrists say.[6] They also say that the crucial time for a single woman is the period approaching thirty. Probably she is unconsciously disturbed that she is still unmarried. She becomes impatient of progress and dissatisfied, not always facing the issue that she may not be mentally and emotionally capable of holding better positions.

In the group of women between forty and fifty are many who are emotionally unprepared for accepting the changes that come with age and feel that in that period they have a right to act a little queerly. In the next group the psychiatrists say are old employees who have given their lives to one organization. Many are highly successful, splendidly adjusted women. But there are pretty apt to be others in the group who have no hesitancy in airing their real or imaginary grievances at changes in the organization. They become trouble-makers and one can not help wondering if too much security in a position is not unhealthy.

For all of these, mental hygienists say there is something that can be done to help place the individual in tune with her surroundings so that she may be given a greater understanding of herself, may be content, may do satisfactory work, may have a harmonious social life and at the same time opportunity for the development and use of her maximum ability. Second skills and diversified interests are also being urged, for it has been found that the woman who has had a variety of jobs is more adaptable and easier to place than the woman who has been in one kind of work over a period of years. There is help from mental hygiene, then, and that is hopeful.

Another cheering aspect is the fact that many studies show that the great discouragement among women that has been so prevalent is changing to a new attitude.[7] An intelligent interest in all of the economic problems that caused the depression and in the reasons for the age discriminations has developed. There is a new sense of activity, planned activity, and an increased interest in the kinds of jobs that women can do. Many women who have had to change their positions are now doing what they had always wanted to do and are much happier than before. Vocational and counseling bureaus are being set up in many lines of work including nursing, where older workers may talk over their problems frankly. All this is hopeful.

### OWNING ONE'S OWN LIFE

To meet the personal responsibility for her own security, a nurse must not only consider these factors in her own character and mentality and age which make for insecurity in employment, but she must also *own her own life*, as Henry Bruère said in *The American Journal of Nursing* last June.

> If one does not save, it is more than likely that one will develop the habit of relying on good fortune to surmount difficulties and to avoid them, with the result that life will sooner or later get out of hand. A backlog breeds self-confidence and ability to act directly. It gives one balanced judgment because one need not so much improvise decisions or face the occasion for calling attention

aggressively to one's merits. Compensation . . . should be based on the recognition of the need of a margin between income and living costs. But that margin should be represented in large part by savings which keep the recipient in a position to meet the daily job mentally, as well as physically, fit.[8]

The following paragraphs have been quoted in the "Study of Incomes, Salaries, and Employment Conditions Affecting Nurses," which has just been published by the American Nurses' Association (page 507). In this study the following recommendations and suggestions for financial security for private duty nurses are so applicable to all nurses that they are being quoted verbatim with the omission of the words "private duty" when they occur.

#### REGARDING INSURANCE

It is recommended:

1. That attention be given by . . . nurses to the matter of providing for insurance.

2. That inasmuch as the three national nursing organizations are sponsoring the plans outlined by the Harmon Association for the Advancement of Nursing, nurses give attention to the types of insurance which are offered by that Association and which it is believed will assist in promoting financial security for the . . . nurse. The two types of insurance offered by the Harmon Association for the Advancement of Nursing are:

*a*. Protected Retirement Income for Nurses (Harmon Plan).

*b*. Group Accident and Sickness Insurance for Nurses (Harmon Plan Supplementary).

3. Further, that nurses become fully informed about other types of insurance which may be beneficial to them and which are recognized as having a desirable status in the insurance world.

4. If a plan for hospital insurance has been adopted in the community and is recognized as offering acceptable hospitalization insurance, it is suggested that where the . . . nurse does not have access to hospital service through the use of rooms endowed by her alumnæ association, she make plans for participation in the accepted group hospitalization plan of her community.

Incidentally, the necessity for providing insurance, insofar as private duty nurses are concerned, is emphasized by the lack of provision for private duty nurses in the Federal Social Security Act. There is a new leaflet recently prepared by the Harmon Association for the Advancement of Nursing called, "Individual Security for Registered Nurses Through Coöperative Group Plans," which is available without cost from the office of the Association, 140 Nassau Street, New York City. The pamphlet tells that payments begin at $5 monthly; that the amount of annuity income obtainable through the Harmon Plan is greater than can be secured at the same cost through any comparable individual contract; that the normal retirement date is sixty or sixty-five years of age; that the cash surrender value at any time before cash payments begin is the total amount of the payments made by the member up to date. It explains about payments to beneficiaries and what happens if a member stops making payments.

It also tells about the group sickness and accident insurance plan, showing that unusually broad coverage is provided without physical examination for all injuries and illnesses, with very few exceptions, no matter what the cause or when the condition began, for a premium of $2.50 per month. It describes the lump-sum benefits for losses of limbs or sight, and the weekly indemnity of $18 during disability up to fifty-two consecutive weeks.

The leaflet also tells about service annuity plans whereby institutions and organizations may provide retirement incomes for registered nurses. Such service annuities, like the individual member's annuities, are purchased from the Metropolitan Life Insurance Company and are guaranteed by it.

Participation in such plans as these is evidence of thrift and shows that a nurse is taking seriously her responsibility for her future financial security;

but there are other ways to keep the wolf from the door. A woman investment broker has summarized them as follows:

1. Live within your means.

2. Save patiently and systematically even though the amount set aside at regular times may be small.

3. Be satisfied with a moderate or even a small rate of interest on your money.

4. Do not play tips.

5. Diversify your investments.

6. Do not take the advice of every Tom, Dick, and Harry for the investing of your money. Seek the guidance of persons qualified by education and experience to give investment counsel.[9]

The same writer has said:

The most dangerous age for women is that dark interlude between the time when she may find herself the unemployed, unplaceable "older woman" and the attainment of the age when insurance annuities start or when she shall be eligible for the old-age pension for indigent persons, or for admission to a home for the aged poor. A well balanced thrift program should give to any woman the security, materially and spiritually, that she dreams of for her sunset years. With some capital of her own, the problem of readjustment of the older woman to a new line of endeavor is greatly diminished. Because of her economic security she can take the time to consider the opportunities that are hers and to retrain if necessary. Furthermore, she is able to keep up her appearance and her standard of living and to maintain a healthy attitude.[9]

Thus speaks the investment broker.

#### OVER FORTY

In a pamphlet written for the National Federation of Business and Professional Women's Clubs the following suggestions about the "over forty" question are given. They apply as much to nurses as to women in business:

Don't be constantly on the defensive.

Don't feel sorry for yourself.

Don't be critical to the young person with or for whom you work.

Don't let success make you smug.[10]

And I would add: Don't be bossy if you are an executive.

The following advice is given in a recent article, "How Can a Woman Begin After Forty?":

Capitalize on your maturity rather than attempt to camouflage it.

It will not hurt you to be frankly forty provided you are alert, vigorous, well preserved and smartly-dressed forty—a forty to which the years have given much more than they have taken away.

Steer as far away as possible from the more crowded and competitive fields and use all the ingenuity and enterprise you have to ferret out some existing need that is not being met in your community, and then find a way to meet it with working skills already in your possession.[11]

The question naturally arises, How can one save and pay for annuities when work is so uncertain and salaries so low, and how can hospitals pay higher salaries or patients higher rates with things as they are? What's the use? Every nurse who reads Dr. Joseph K. Hart's article, "Economic Security for Nurses—Through Trade Unionism or—?" in the April issue of *The American Journal of Nursing* cannot help but feel that there is ultimately a way out if we continue to work together with a definite program. She will have a lifting of the spirit because of his objective, impersonal interpretation of some of our problems and his observations about some of the values and trends in our own profession that it has been hard for us to see.

#### SOUND PLANNING

For sound planning for our profession, however, we must have sound planning for ourselves individually, and have our own personal programs for economic security. In such programs I submit that there are three important parts: (1) Watching all those factors in ourselves that tend to make us less employable, (2) Practicing mental hygiene on ourselves so that we may recognize and

control those personality changes that creep up on us as the years advance, (3) Beginning as young as possible to build up a backlog of savings, and dropping out an anchor to windward by putting as much as we possibly can into some recognized plan for a future retirement program. Planned security is our individual responsibility.

Presented before the Joint Session of the three national nursing organizations, Biennial Convention, Kansas City, Missouri, April 27, 1938. Published in *The American Journal of Nursing*, June 1938.

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## PLACEMENT SERVICE FOR PUBLIC HEALTH NURSING

AMELIA GRANT, President of the National Organization for Public Health Nursing, made the following announcement at the N.O.P.H.N. Business Meeting at Kansas City, Missouri, April 29, 1938:

You have read the final recommendations of the Committee to Study the Functions of the National Organization for Public Health Nursing, which were accepted by the Board of Directors of the Organization, and appeared in the April number of the magazine. Those related to placement service read as follows:

That placement and vocational guidance problems in nursing are not only national in scope but are the concern of the three national nursing organizations.

That the responsibility of the N.O.P.H.N. lies in counseling rather than actual placement, and in view of the fact that more local, state, and regional placement bureaus are being organized, it is recommended that the organization place its emphasis on standard-setting for placement bureaus and counseling through office and field service, rather than on placement.

Many groups and committees have participated in formulating these recommendations. More than a year ago, we began an intensive study of the problems related to placement service. The results of these studies were brought to the Board of Directors at this Biennial Convention meeting, and the following action was taken. It was decided:

That the N.O.P.H.N. discontinue our relationship with the Joint Vocational Service on the first of July 1938; that placement service be transferred to the Nurse Placement Service in Chicago, Illinois, pending the development of contemplated regional placement services throughout the country; and that the N.O.P.H.N. appoint a committee to study and guide vocational service.

The Board took this action after considering these factors:

While our close affiliation with the

social work group through the Joint Vocational Service has been of very real value to public health nursing and is still important, it is apparent that public health nursing placement should be associated with the other fields of nursing in which the needs and demands are more and more closely related to public health nursing. Positions in administration, supervision, and teaching are calling for a public health nursing background and more and more public health nurses are looking with interest toward such positions in schools of nursing and colleges.

Further, it is believed that placement can be more satisfactorily carried on through regional services, since the regional plan brings the service closer to the agency and the nurse using it; and yet the national scope can be maintained by having a central index of available positions and nurses.

The Board recognizes the responsibility of the N.O.P.H.N. for vocational guidance and believes that vocational guidance, placement, and education are closely allied and that each activity strengthens the other.

The advisory committee, which will be national in representation, will serve by:

Continuing the study of vocational placement problems

Setting standards for placement service

Stimulating local sponsorship for such services

Developing machinery for correlating regional bureaus

Acting in an advisory capacity on public health nursing problems in the Nurse Placement Service in Chicago and in other bureaus as they develop.

After July 1, 1938, therefore, it is suggested that public health nurses and their employers request service from the Nurse Placement Service, 8 South Michigan Avenue, Chicago, Illinois. Arrangements will be made for the transferral of nurses' vocational records from the Joint Vocational Service to Nurse Placement Service *upon request* of the individual nurse. If no request is received, the vocational records will be stored by the N.O.P.H.N.

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The revisions in the N.O.P.H.N. by-laws were accepted as sent to the membership.

# An Educator Looks at School Health

By HENRY J. OTTO, PH.D.
Consultant in Education, W. K. Kellogg Foundation, Battle Creek, Michigan

**Stimulating and challenging is this article in which a number of weaknesses in the school health program are pointed out and suggestions made for their improvement**

HEALTH EDUCATION is one of the new responsibilities which the schools have acquired. This new acquisition has come about largely during the twentieth century and more specifically during the last twenty years. Increased attention to the whole child as an integrated organism engaged in the learning process has focused interest upon the physical condition of children. Then, too, much greater value is placed upon the individual life and upon the continuous efficient functioning of one's body. Research in medicine has given increasing evidence that many human ailments can be prevented if people, as individuals and as groups, will take the necessary precautions. To be able to prevent disease and accident necessitates knowledge of how to safeguard one's health.

It is a combination of the above factors which has placed increasing importance upon health as a field of instruction. In fact, practically every list of educational objectives acknowledges the significance of health instruction by placing it at the top of the list. It seems clear that the educator has accepted the responsibility for health education. It is also a generally acknowledged fact that the typical school administrator and classroom teacher have not known very much about methods and procedures in health education. It was only natural that they should turn for advice and guidance to those who were specifically trained in the health field—physicians, dentists, psychiatrists, and nurses. Undoubtedly these specialists in health were none too sure as to the most effective procedures in health education, but a beginning had to be made somewhere. It was made, and we have now had nearly twenty years of experience with a variety of procedures and set-ups.

The time is now appropriate to make an inventory of the situation, to discuss common problems, and to pool our ideas for the improvement of practices in the future. School nurses are the largest body of specialized school health workers in the country. The writer is a generalist in elementary education and a layman in the field of health education, and this article deals with the observations of a layman regarding present practices in health education.

## PRINCIPLES NOT PRACTICED

There are several elements of the school health program which seem to be inconsistent with generally accepted theories in education. They are as follows:

1. *The lack of emphasis on health education.*

Almost every list of educational objectives that has been published in the last twenty years has placed health at the top of the list, thereby indicating its importance in the school program. An examination of teaching emphases in the majority of public schools at present shows that in terms of time allotments and amount of teacher and pupil effort, the attention given to health education

is just about the reverse of the significance implied in the statements of educational objectives.

2. *The comparative ineffectiveness of present health instruction procedures.*

Health instruction is undoubtedly the most ineffective teaching which is done in any part of the school curriculum at the present time. In spite of the time and attention which are being given to health work, it is generally recognized that the results of such teaching are not very great. Habits and attitudes regarding health practices are influenced but slightly by our health teaching procedures. This state of affairs is probably due to the fact that we have not learned how to teach health as well as we have learned how to teach other subjects, such as reading, arithmetic, spelling, and penmanship. Volumes are written on methodology in the more conventional fields of the elementary school curriculum, but there are very few research studies dealing with methods of teaching health.

A second possible explanation for the ineffectiveness of health instruction is the fact that the majority of health habits are practiced at home. We preach about them in school, but the child does not have much opportunity to practice them in school.

3. *The apparent total neglect of mental health.*

In the typical school, problems of emotional and social adjustment seem to be completely neglected. The result is maladjustment, truancy, and behavior problems.

4. *School schedules.*

Many teachers' daily schedules violate some of our best principles of mental hygiene and integrated learning. The school day, particularly in rural schools, is divided into so many short recitations that the majority of generally accepted principles of learning and the organization of learning activities are violated.

5. *Methods of motivating children.*

Methods of motivating children are based largely on fear—fear of failure, fear of reprimands from parents, fear of having to stay after school, fear of competition from associates, fear of examinations.

6. *Control of communicable disease as related to the drive for one hundred percent attendance.*

The banners, blue ribbons, and stars which are awarded for attendance in thousands of American schools today are doing a great deal to jeopardize the teacher's part in the control of communicable diseases. Competition in attendance, which brings the social pressure of the group to bear on the individual child so that he will not wish to be absent unless he is seriously ill, makes it difficult for parents to keep children at home during the early stages of a contagious disease, even though they may be interested in preventing the spread of such disease. In fact, the whole plan of competitive awards for high percentages of attendance is contrary to accepted principles of public health procedure.

## CORRECTION OF DEFECTS

The efficiency of machinery for the correction of physical defects should be greatly improved. An extensive recent study conducted under the auspices of the American Child Health Association revealed alarming inefficiencies in existing procedures designed to secure correction of physical defects.*

Of 100 children having vision defects, only 2 actually obtained the necessary corrective services. The machinery for corrective services can only be improved by finding out wherein the services failed

*American Child Health Association. Physical Defects: The Pathway to Correction. 1934. Pages 43, 59, 69, 89, 91. Obtainable from American Public Health Association, 50 West 50 Street, New York, N. Y.

to care for the needs of the remaining 98 children. In 37 cases the recommendation was neglected by someone as follows: by the school health staff, 17 cases; by the follow-up service, 12 cases; by the parents, 8 cases. The services went wrong in some respect in 61 cases as follows: the examining service failed to find the defect in 23 cases; a conflict of opinion prevented further follow-up in 11 cases; there was follow-up but no definite appointment in 21 cases; the parent was unconvinced and the school had no further plans for follow-up in 6 cases. Only 37 cases got to the parents and of those only 16 appointments were made.

The same study revealed similar inadequacies in the machinery for the correction of dental defects, ear defects, defective nutrition, and needed tonsillectomies.

### THE MEDICAL EXAMINATION

The effectiveness of an annual medical examination for every child is questionable. The same study conducted under the auspices of the American Child Health Association aimed to discover some of the reasons for the breaking down of the machinery for the correction of defects. One of the factors to which attention was called was the ratio of health workers in the New York City schools, where the study was made, to the number of children and teachers to be served. There were approximately 760,000 elementary school children distributed among 635 school buildings. For each 100,000 children there were approximately 2700 teachers, 40 school nurses, 7 school physicians, 2 school dentists, and 3 dental hygienists.

The question is raised whether, under such circumstances, it is wise to bring the school physician regularly into direct contact with all, or even a considerable portion, of these children, as in the present routine health examinations. An annual health examination for every child is a tempting ideal. But in trying to achieve it with limited personnel, we have brought about over the country generally a widespread system of cursory and superficial medical inspections which frequently fills the record cards with recommendations, some of doubtful significance, and in such overwhelming volume as to make their follow-up an impossibility. The committee pointed out that we need to preserve the quality of the examination, even at the cost of restricting service to lesser numbers. In view of this need, the question is raised whether it might not be advisable to relieve the pressure for an annual health examination for every child, and in its stead, adjust the frequency of the examinations to a figure which would insure a high quality of service and effective procedures for the correction of defects.*

### HOW IMPROVE THE PROGRAM?

The following suggestions are made for correcting inadequacies and improving the school health program:

*1. Modify the training of personnel, including school nurses, classroom teachers, and school administrators.*

School nurses and other specialized school health workers should have more training in the general curriculum and methods of the elementary school. At present the typical preservice training program for school nurses, physicians, and physical-education teachers is designed to prepare them for specialized work and for the teaching of special subjects in the public schools.

In the secondary school in which the present typical program of subjects is highly departmentalized, the special teacher of health, personal hygiene, and child care readily finds his place with other special teachers of English, mathematics, science, and social studies. In the elementary school, however, the situation is somewhat different. In practically all of the rural and smaller vil-

*Ibid. Pages 120-122.

lage elementary schools there is little or no departmentalization below the seventh grade. Even in many of the larger city elementary schools there is either partial departmentalization or none. The specialized teacher thus finds it much more difficult to organize a course in such a set-up.

There is another aspect of elementary education which is much more significant than the question of departmental organization of instruction; namely, the curriculum based on the child-development theory which stresses children's experiences.

This involves a thorough consideration of the fact that the "whole child" comes to school; that the effectiveness of the teacher's work depends upon the background which the child brings to school, the condition of health and emotional balance in which the child is found on any one day, the social adjustment of the child in the class group, the maturation of the various elements of the total child as it relates to the child's receptiveness to new ideas, and the thorough adaptation of instruction to individual differences in maturity, ability, needs, and interests. All of this is coupled with the fundamental concept that education is a developmental process, not a teaching job, and that the most fundamental learnings take place at the same time that one is participating in real and vital experiences. "Learning to do by doing" is not an empty verbalism, but a fundamental principle for the organization of curricula and classroom procedures.

Now, what does all of this have to do with the training of personnel in the health field? It means that the typical arid courses in educational psychology and general methods of teaching are not only quite inadequate but are likely to give the uninitiated wrong conceptions of the educative process and the functions of a teacher. It means that persons schooled only in the methods of the secondary school are not only quite helpless in the elementary school, but actually obstruct the elementary school in giving expression to this newer philosophy. Our experience has been, year after year, that persons trained for teaching special subject areas of the secondary school must be almost completely reëducated before they can function effectively in an elementary school program based upon the child-centered curriculum.

As far as health instruction is concerned, it means a fundamental difference in point of view. Instead of courses of study to be covered and textbooks to be completed, it means discovering the health-instruction needs of pupils and then leading children into classroom activities which will give experience with the fundamental learnings.

If I were responsible for planning the preservice program for health workers, especially school nurses, I would do—or avoid doing—several things, namely:

1. Stop trying to prepare them for elementary and secondary school work through a few isolated courses.

2. Abandon their taking of the standardized courses in educational psychology and in general methods of teaching in the secondary school.

3. Stop trying to select from existing courses in education the 12 or 15 hours most appropriate or least inappropriate for nurses. I would confer with the staff of the department of education and develop courses in education peculiarly suited to the needs of nurses.

4. Have nurses take fundamental courses in child development, and see to it that the methods used in teaching these courses harmonized with the philosophy and psychology expounded in the courses.

5. Make the educational courses for nurses laboratory courses in which the nurse could learn the principles of child development and the experience curriculum by actual work with children.

These things which I have mentioned as common practices and points of view in the elementary school are now rapidly beginning to take root in secondary education so that within the next fifteen years you may anticipate similar circumstances in the high school.

Classroom teachers and school administrators should have more training in health—not necessarily more courses in health education, but a clearer concept of the biological basis of child growth and development and of the physiological oneness of the whole child. Three specific suggestions come to mind at once which might be inaugurated to begin to meet this need:

1. Modify the existing freshman college course in personal hygiene so as to make it vital and functional in the lives of the persons taking it. The most outstanding outcome of the present content and methods of the personal hygiene course is the students' profound dislike for the subject and an everlasting prejudice against anything that has the word health or hygiene connected with it. All college students have many questions in the health field with which they should appreciate help and guidance, but these questions do not happen to deal with the structure and function of the various parts of the human skeleton, the nervous system, and the circulatory system. If the college course in personal and community hygiene could be built around topics about which these people really desire information, the course could be made so vital and meaningful that the students would be everlasting boosters for the health program.

2. Instead of some of the present courses in education, teachers should have an opportunity to become familiar with the basic facts and principles of child development—physical, mental, social, and emotional—and the interrelation between mental and academic development and these other development factors. Teachers should have a fundamental understanding of how children grow.

3. A much larger proportion of the teachers' courses in education should be of the type which bring them into extensive, intimate contact with children. Student teaching at present is on the afternoon social call basis, where they run in and run out of the training school within a period of forty minutes. Student teaching should give the prospective teacher all-day contacts with children over a period of several months, this to be supplemented with experience in camps in which the teachers live with children twenty-four hours a day for several weeks. At present the chief obstacle to the teacher's effectiveness in health work is that teachers do not know or understand adequately the children with whom they are working.

2. *Place the medical examination phase of the school health program on a basis which will result in more adequate correction of defects.*

Two proposals that have been suggested by a number of persons come to mind:

Instead of having health examinations given by school physicians, let the child have his examination made by his family physician to whom he would have to go anyhow for needed corrective work. Several research studies have shown that the school health machinery breaks down miserably at the point at which corrections are to be made. Many persons have given serious thought to ways and means of improving this phase of school health service, but very few have questioned the fundamental machinery itself. Perhaps we ought to spend our time in developing a new machinery instead of tinkering up the old.

Economize the time of school nurses by relieving them of the duties associated with the inspection of children deviating from normal health. It seems

to be common knowledge, and several research studies have substantiated the fact, that the classroom teacher who sees the child every day, and in many cases all day, is in a better position to observe when a child is deviating from normal health than is the school nurse who sees the child very infrequently. Perhaps, if some of the time thus saved by the nurse were spent on the corrective program, better results could be secured.

3. *Place health instruction on a functional basis.*

We have learned that the most effective learning takes place through the experience method, especially if the topics studied consider the immediate needs and practices of children. In the health field we have adopted the term "daily healthful living." But how much of our health teaching conforms to this? We still have the ten- or fifteen-minute hygiene period two or three times a week, the assignment of the next ten pages in the adopted text, a special teacher of health or a nurse dashing from one room to another and from one building to another to meet all the schedules, and one person trying to teach the subject to several hundred pupils each semester and not being able to know any of the pupils well enough to gear the health instruction around the health needs and practices of the particular group of pupils.

4. *Let the correlation between health instruction in school and the practicing of health habits at home be an important function of the school nurse.*

The nurse, through her contacts in the home, can give the teacher pertinent facts regarding the home backgrounds of pupils, the general pattern of life in the homes, the nature of health practices at home, and the opportunities which pupils have for practicing the health habits discussed in school. The nurse can give the teacher many helpful suggestions on methods and content in health instruction. Through frequent conferences between teacher and nurse, the nurse can give support in the homes to the health principles taught in school. The nurse can aid the teacher in making helpful home contacts and can also assist the teacher with mothers' clubs or child-study clubs.

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Presented before the N.O.P.H.N. Round Table for School Nurses, Biennial Convention, Kansas City, Missouri, April 27, 1938.

**ATTENTION SCHOOL NURSES: The American Association for Health, Physical Education, and Recreation will meet with the National Education Association at the Hotel Pennsylvania, in New York City, June 26-30.**

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# Prevention of Orthopedic Disabilities

By ROBERT McE. SCHAUFFLER, M.D.
Kansas City, Missouri

**The public health nurse should increase her knowledge and sharpen her powers of observation so that she can recognize when a child is sick or crippled**

PREVENTIVE medicine might be called a specialty, but in a larger sense it is part of the duty of all doctors and nurses. The obligation and the practice of preventive medicine cannot be arbitrarily divided between the specialties of medicine. The work of the internist, the pediatrician, the orthopedist, and all of the other specialists must overlap and they have many things in common. This discussion will dwell on some of the opportunities in prevention which are of special interest to the orthopedist and perhaps especially his duty, but it must be understood that they are not exclusively his province.

The problems and efforts of preventive medicine may be divided into two parts. The first part of the program attempts to prevent the occurrence of disease or disability. The second, by early recognition of a disease or abnormal condition, attempts to effect an early cure or greatly to minimize the damage likely to be done.

In the first group of diseases are included those about which we already have enough knowledge to exterminate them if we rightly apply what we know about the control of sources of infection, the use of immunizing inoculations, and other preventive measures. Among communicable diseases typhoid fever, smallpox, and diphtheria should be almost completely stamped out.

Many deficiency diseases due to lack of vitamins or other biological products can be almost completely controlled by supplying the missing biochemical product. Rickets, diabetes, and pernicious anemia are examples of this group.

Diseases due to too much or too little of some ductless-gland product are more difficult to control. The endocrine actions and reactions are very complicated, but great progress is being made in this field.

Among the diseases of the second group, about which we have not enough information to control the cause, are poliomyelitis and cancer. Much can be done in the prevention of disability from such diseases, by early diagnosis and early treatment.

In my lectures to nurses on orthopedic surgery I divide the cases into four groups:

1. Cripples by birth
2. Cripples by accident
3. Cripples by disease
4. Cripples by faulty use of the body (This includes postural and some occupational disabilities.)

We will for convenience approach the subject under the same headings.

### CRIPPLES BY BIRTH

Cripples by birth include those who suffer from congenital deformities and birth injuries. Obviously no one knows how to prevent children being born with clubfeet, congenital dislocation of the hips, cervical ribs, or many other conditions. Much can be done by the early recognition of congenital deformities on the part of nurses, and by putting the child under the early care and treatment of skilled orthopedists.

The newborn baby who starts breath-

ing with difficulty and who has recurrence of respiratory failure or has convulsions or undue stupor may well be suspected of having an intracranial hemorrhage at a time when decompression or spinal puncture may be of great value. Likewise in later months the occurrence of spastic-contracture deformities may be prevented, and later operations made unnecessary.

Much would be gained by the early recognition of obstetrical partial paralysis due to brachial-plexus injuries, and by the prompt placing of the arm in the most favorable position.

#### CRIPPLES BY ACCIDENT

Safety measures in the home, at school, and on the streets are the duty of every intelligent citizen, but they will not be discussed in this paper.

#### CRIPPLES FROM DISEASE

*Syphilis*

The most important congenital disease is syphilis. We ought to proclaim from the housetops that there is no good reason why another child should be born with congenital syphilis in the United States. Routine Wassermann tests of all pregnant women should be made. And vigorous treatment during pregnancy of the prospective mother with a positive Wassermann is an almost certain guarantee that her child will not have congenital syphilis.

It was a red-letter day in March 1938 when Governor Lehman of New York signed the bill making blood tests of pregnant women compulsory. With this start in New York State we ought to push forward rapidly for widespread voluntary compliance with this wise precaution and for laws to make it compulsory for the ignorant and the indifferent.

*Tuberculosis of the bones and joints*

The disease which produced the greatest number of crippled children which we saw in orthopedic hospitals up to the last twenty-five years was tuberculosis of bones and joints. No chapter in the history of preventive medicine is more encouraging than that which records the progress of the fight against the white plague. Tuberculosis is a disease for which there is no specific treatment and no method of immunization. About all that could be done was to clean up the dairy herds, to segregate the more severe cases in hospitals or sanatoria, and to offer special care to the contacts.

It was mostly a matter of education of the general public and of the afflicted persons and their families. Wonderful progress has been made. But just because we see so many fewer cases of bone and joint tuberculosis than formerly, there is need that we should be especially on the lookout for the few new cases so as to spot them early. Any long continued soreness of a single joint should arouse suspicion and lead to an investigation. The experienced orthopedic surgeon will make a biopsy if the diagnosis is not clear otherwise.

*Osteomyelitis*

This usually has an acute onset with early blood-stream infection and localization in a bone or several bones. Usually organisms gain access to the blood-stream from some small carbuncle or boil or a superficial infection with a small abscess. All too often the mother precipitates the invasion by pricking the local lesion with a needle or prying up a scab and then trying to squeeze out the pus through a tiny opening. Throat and ear infections account for most of the remaining cases.

Often the final or localizing cause is an injury. This is a common story: The child fell at play or had a blow which bruised a bone near a joint. He made considerable complaint at the time and perhaps for the rest of the day. By the next morning the injury was forgotten. Two days later the child slows down, does not want to play, and has pain in the limb which was injured. That night he has a great deal of pain and a fever, and by the next day looks

very sick. The injury is remembered, and a fracture or sprain is thought of. But neither of these conditions causes any considerable fever. Then rheumatism is considered. But acute rheumatism with fever in children almost never affects only one joint. Besides, close observation shows that the worst pain is in the limb near a joint, not in a joint.

No time should be lost in getting such a child to a hospital. The wise surgeon will not wait for an abscess to appear and he will pay no attention to the fact that the x-ray is negative. He will not even wait for the blood culture which has been taken and which will be positive in 24 or 48 hours. The surgeon will operate at once, making drill holes in the bone between the marrow cavity and the epiphyseal line, and pus will come from some of them. This early operation may save the child a year or two of invalidism and several operations.

Many doctors fail to make the diagnosis of osteomyelitis early. The nurse can be of great service if she gets this vision of the onset of osteomyelitis and urges parents to obtain prompt and competent surgical attention.

*Rheumatic arthritis*

This is one of the unsolved problems of medicine. There are more people in the United States crippled by rheumatism than any other disease. The mortality is not high but the disability reaches an appalling total.

With children the disease is very simple or else extremely complicated and difficult. I sometimes say with slight exaggeration that when a child is admitted to the hospital with rheumatism I can cure it in three weeks or arrest the disease in three years. This means that the child in the first group has a simple infectious arthritis. With rest, proper food, medication, and the removal or treatment of some obvious focus of infection like diseased tonsils, mastoiditis, or infection of the intestinal tract, an early cure may be expected.

The child in the second group has a constitution predisposed to rheumatism, and an infection just "starts the ball rolling." These children are naturally slender and poorly nourished. They are usually visceroptotic. They have thin, sensitive skins and mucous membranes. They have an unstable vasomotor system and flush and pale easily. They have poor resistance to infections. They are usually smart and active but tire easily. They are sensitive and easily emotionally upset. With these unhappy children it is largely a matter of luck how early they get an infection which starts the rheumatism. Those in poor surroundings with inadequate food and clothing usually succumb first. However, if through a favorable environment and good luck they escape in childhood and adolescence they come down with arthritis in the third or fourth decades under the stress of life.

Every case of rheumatism should be taken seriously and many should be hospitalized. Early and persistent treatment is all-important. The time at which treatment is started is almost as important as it is in tuberculosis or cancer.

*Poliomyelitis*

There is still some scientific uncertainty as to the cause of this disease—whether it be a living filterable organism, or a virus—some potent chemical product.

While there are many scientific uncertainties in connection with this disease, there is little doubt of the fact that the usual portal of entry is the nose, along or through the filaments of the olfactory nerves. It seems certain that a high percentage of temporary protection can be gained by spraying the upper nose with an astringent solution. This seems simple and sure in monkeys. It is difficult and less sure in the noses of human beings, largely because of the mechanical difficulty of reaching all the nerve terminals. It seems evident that

only a skillful nose and throat physician or someone especially trained by him can do the spraying of the nose in an effective manner. In spite of this difficulty the method will probably prove of great value at the outbreak of major epidemics.

The rest of the story is simple but needs to be repeated often.* It includes rest, spinal punctures, and good nursing care for the acute stage; respirators conveniently available for the small group of unfortunates who have paralysis of the respiratory centers or nerves; prevention of deformity from the moment of diagnosis and for months and years afterward, accomplished by light, removable splints, supports, and braces; the keeping up of the nutrition of the muscles by massage; and, as recovery begins, the slow inauguration of special exercises for muscle training.

This muscle training may be a task extending over many years and is graded, like the education of a child, from kindergarten on up. It is not possible to enumerate here the many operations devised and perfected by orthopedic surgeons for improving the condition of these patients. The time for operation is seldom before the second year or later, and every child is an individual problem.

The public health nurse can be of the greatest help by instructing and encouraging parents, and by inspecting braces and shoes and making a constant agitation to have them kept in repair. She can find neglected cases and get them to clinics for crippled children. She can be everlastingly on the trail of children in course of treatment to get them to return regularly to the orthopedic centers. She can advise about schools and proper games and the search for occupational training suitable to the patient. Finally she can assist in the placement of these individuals in some job.

*Overuse of immature bones*

There is a group of cases where disability and perhaps deformity are caused by the overuse of immature bones. This most commonly occurs (1) in the head and neck of the femur, where it is called Perthes' disease, (2) at the tubercle of the tibia, where the extension of the quadriceps muscle is attached, where it is called Osgood-Schlatter's disease, (3) in the scaphoid bone in the arch of the foot, where it is called Köhler's disease.

They are all the same process. Under strain the bone softens, and part of it turns back to cartilage. It becomes misshapen, and it is somewhat painful. Usually the boy has suddenly become ambitious to excel as a jumper or hurdler, or the girl as a ballet dancer. Most of the patients are at the age of puberty but in some it begins much younger. These younger children usually have a history of being delicate and undernourished in early childhood.

The diagnosis may be suspected by any trained observer and promptly proven or disproven by x-ray pictures. All recover in a year or two with proper treatment.

### CRIPPLES BY FAULTY USE OF BODY

The fourth general class is that of cripples by the faulty use of the body. These are mostly postural or occupational in cause. The postural cases fall into two groups:

1. *Variations in the normal antero-posterior curves of the spine*

The common type is the slump-posture. The children are usually thin and long-waisted. They have an exaggerated lumbar lordosis (hollow back), round dorsal spine, and round shoulders. The head is too far forward. Almost every internal organ is affected. They

*NOTE: Two articles of special interest on this subject appeared under the title of "The Essential Features of Poliomyelitis," by T. Campbell Thompson, M.D., in PUBLIC HEALTH NURSING, March and April 1938. See also "Home Care of Poliomyelitis Patients," by Jessie Stevenson, R.N., in the May issue and on page 390 of this issue.

have poor expansion of the upper chest, poor circulation, and downward displacement of the abdominal organs, with indigestion, constipation, poor nutrition, sometimes urinary difficulty, menstrual disturbances in girls after puberty, and sometimes chronic backache. It is true some of these symptoms may not appear until adult life, but the time for the correction of the trouble is in childhood and adolescence.

A great field is open to public health nurses—and for that matter teachers and parents—in the early recognition of faulty posture, and in earnest efforts to make the child posture-conscious, and to overcome the trouble by posture training and exercises.

*2. Lateral deviations of the spine*

These are usually first apparent from a high shoulder or unequally prominent hips. Then inspection of the back discloses a beginning S-shaped curve.

In the more severe cases we must rule out poliomyelitis by the history, and congenital malformation of the vertebræ by x-rays, before deciding that the case is a postural or functional scoliosis. It is also important to note at once whether one leg is actually a good deal shorter than the other, thus causing a tilting of the pelvis, and the beginning of a lateral curve.

Bad habits, such as standing with one knee slacked, carrying a weight on one hip, or sitting sideways on a chair or sofa, may be enough to start a curvature of the spine in a rather flabby individual.

If these cases are noticed early they can be cured by correction of bad habits, posture training, and corrective exercises. If they are a little more advanced, plaster casts and a brace are necessary. Advanced cases with severe deformity cannot be corrected by the most skillful orthopedic surgeon. All that can be done is to make a partial correction and do an extensive arthrodesis on the spine.

In few chronic conditions are early recognition and treatment more important than in lateral curvature of the spine.

President Roosevelt's committee on a national health program recently made a report through its chairman, Josephine Roche.* This paper will omit the important discussion of the economic barriers between those in need of medical service and those prepared and equipped to furnish it.

The report goes on so say that in the last fifty years such diseases as malaria, smallpox, typhoid fever, tuberculosis, yellow fever, and diphtheria have been almost eliminated or greatly reduced, with a saving of 750,000 lives a year. They have been conquered by such measures as the supervision of water supplies, the pasteurization of milk, elimination of mosquitoes, and by inoculation. In the future the diseases to be attacked must be treated personally, rather than by mass attack.

This throws a greatly increased burden on the public health nurse and an added responsibility on the medical profession. You will have to consider all sorts of problems of diet, habits of living, working conditions, and opportunities for play. You will have to take into account emotional strains and maladjustments.

You will have not only to increase your knowledge but to sharpen your powers of observation. It is surprising how much can be learned by the trained medical clinician by the use of his senses without aid from laboratory or x-ray. There is special opportunity to display your skill in this line in the detection of orthopedic defects and diseases.

You notice that an individual limps or is lame. Further skillful observation

*Interdepartmental Committee to Coördinate Health and Welfare Activities. The Need for a National Health Program. Report of the Technical Committee on Medical Care. Washington, D.C., 1938.

should discover whether the cause is a sore foot, or a short leg, or some trouble with the knee or hip or back. You should observe people sitting and standing, walking and running, bending and turning. The poise of the body or the use of the hands may give you important clues. The observation of a child at play when he is off guard will reveal much more about his condition than an inspection when he has been called in to see the nurse and consciously or unconsciously tries to appear at his best.

It is necessary that a good public health nurse should be a good clinician. By her own observation she should recognize that a child is sick or crippled. She should be able to make a tentative diagnosis, and know what might be or probably is the matter with him.

I am sorry to say that many physicians do not agree with me. They are jealous of a nurse who knows too much. They want to have a monopoly on all medical information. They want echo-nurses to spread their wise sayings. They want rubber-stamp nurses who merely obey written orders and printed rules.

No, that is not the kind of nurse I want. I want a nurse who is an assistant, a junior partner—a nurse who is observing my patient, thinking of the meaning of what she sees, collecting data which will assist me in diagnosis and treatment, trying to fit the treatment to the idiosyncrasies of my patient.

Soldiers in mass formation may be commanded by the higher officers. When they are on the skirmish-line or have gone over the top and are straggling over the shell-pocked fields or in the ruined houses of the village it is the sergeants who are all-important.

Nurses may be reduced to near-dummies in the crowded formation of the great hospital but on the far-flung skirmish-line of public health nursing they must be shrewd and war-wise sergeants.

We are soldiers together in a great war against disease and its federated allies—ignorance, indifference, and selfishness. Our battle line is not alone on the frontiers and ports of entry. It extends into every city street and every country lane.

I honor you, I congratulate you on successes already won. I wish you God-speed. I am sure that you will march forward to greater victories for the health and happiness of the American people.

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Presented before the N.O.P.H.N. General Session, Biennial Convention, Kansas City, Missouri, April 29, 1938.

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## SNOW WHITE ATTENDS MEMBERSHIP RALLY

Membership chairmen or their representatives from 41 states answered the roll call and reported on membership in their states at the N.O.P.H.N. Membership Rally Luncheon, which packed the Hotel Baltimore dining room at the Biennial Convention in Kansas City with 606 guests—106 more than space reservations had anticipated! Mrs. John A. Haskell, Vice-Chairman of the national Membership Committee and President of the Visiting Nurse Association of St. Louis, presided and called the roll of states. The St. Louis nurses entertained the guests with a play, presenting in "A Modern Version of an Old Story, with Apologies to Mr. Grimm and Mr. Disney," Snow White and the Seven Dwarfs, showing the famous princess as a modern public health nurse conquering disease and ignorance as personified by the tragi-comical dwarfs.

# Getting Along with People

By LLOYD R. SHERRILL
Personnel Manager, Montgomery Ward and Company, Kansas City, Missouri

**The public health nurse in industry teaches people how to help themselves. To do this she must have the confidence and respect of the entire personnel**

THE ABILITY to get along with people is perhaps the most important personal qualification of the public health nurse in industry. My discussion of this subject will include (1) what the job of industrial nurse consists of, (2) why it is important that she be able to get along with people, (3) how to get along with people. First, I will define for you what in my opinion are the duties of an industrial nurse. They are as follows:

1. Acting on safety committee to bring to attention first-hand experience with causes of accidents, and promote education in working safely.
2. Assisting the plant physician with examinations and other routines.
3. Associating with employees to develop a spirit of friendliness and understanding toward the medical department and the company.
4. Checking plant conditions of work which may be predisposing causes of colds, such as drafts and congested departments.
5. Controlling illness cases by the removal of sick employees from the job, and by approving their return to work in cases of minor illness.
6. Coöperating with the personnel manager in regard to physical, mental, and social problems of employees.
7. Giving advice; counseling.
8. Giving preliminary examinations—including the taking of medical histories and making of visual tests and color tests.
9. Handling compensation records and payments.
10. Inspecting the plant to maintain sanitary standards especially in regard to the cafe, washrooms, drinking fountains, and cloakrooms.
11. Keeping the medical unit clean and orderly.
12. Knowing company policies.
13. Making home visits to give health advice, and to ascertain and verify causes of disability.
14. Providing first aid to the injured.
15. Supervising the maintenance of accurate and complete medical, accident, and lost-time records.

It seems to me that industry is going through a new birth; that during the last few years points of view have undergone tremendous changes. One important change which has occurred has been a greater consideration for the human element in business. There is a growing appreciation of the necessity for happiness and contentment among employees and their relationship to satisfactory job performance. I mean simply this: that industry is willing—not as an expense, but as an investment—to place more money in building morale and developing leadership, to replace yesterday's "drivership" for results.

Changed conditions have placed more stress on such things as the necessity for the right selection of candidates for employment, the importance of reducing lost time due to illness, and the need for reduction and prevention of accidents. Positive steps in this direction have been the sponsorship of group life-insurance plans, medical and hospitalization benefit plans, and credit unions. These are milestones in management's keen interest in employees' general well-being, health, and security.

These points have a direct bearing on the activities of the personnel depart-

ment and its copartner, the medical department, in industry. These departments as units are charged with extremely important responsibilities, without real authority. In other words they are service organizations established to carry out certain fundamental company policies, but with no administrative power.

What has been the trend in the medical departments? About thirty-five years ago, industry had a real problem in employment stability, since we are told that in certain situations it became necessary to hire five employees in order to keep two on the job. This meant that 60 percent of the payroll was constantly incapacitated.

The establishment of medical units in business—which were mere first aid stations to begin with—along with a general improvement in public health standards resulted in the development of programs to prevent and control sickness and injury. The one person most responsible for these programs in industry, because of her full-time duty in the medical department, is the industrial nurse. In other words the success or failure of the medical department is determined to a great extent by the nurse.

#### DEAN OF WOMEN IN BUSINESS

In the past few years management has recognized the need for strengthening the front-line defense in regard to human relationships. Many of the "labor pains" experienced could have been avoided had a better understanding existed. The nurse has been delegated with more and more responsibility for assisting in maintaining the physical, mental, and spiritual well-being of employees. You will note that this requirement is far-reaching and involves fields of endeavor heretofore given little regard. The nurse has become a dean of women in business.

The personnel unit—and I want to include the medical department inasmuch as it is an integral part of the personnel unit—has a dual responsibility to management and to employees. It is the go-between where real or imaginary cases of mistreatment can be given a fair hearing. We naturally have cases where employees are unreasonable, and other cases where foremen, in their desire to obtain a better performance, have unwittingly mistreated individuals by overlooking the human element.

I have tried to give you some idea of the industrial nurse's job, considering what she does and why she does it. It is my belief that a public health nurse in industry may have all the attributes required from a sound technical viewpoint, may have the necessary ability and knowledge of the fundamentals of nursing, and may be immaculate in her fresh uniform; but if she lacks the ability to get along with human beings, then she is a failure as an industrial nurse.

#### NO TWO INDIVIDUALS ARE THE SAME

It has been mentioned that the nurse is charged with a responsibility for the physical, mental, and spiritual well-being of employees. Carrying out this task requires the application of practical psychology. It requires especially an understanding that no two individuals are the same; that each person is made up of a mixture of qualities to such an extent that he reacts in his own individual way to different stimuli or methods of approach.

We could place 600 machines in a room and they would run at the same speed under the same conditions, but with 600 individuals we have 600 different units and each must be considered separately. For the best results some people have to be continually encouraged and patted on the back, so to speak. Others must be left alone, and others must be prodded. We must know when to pat, when to let alone, and when to prod, and of course how to influence people by these various methods.

The industrial nurse must apply practical psychology in her job. She must gain the admiration and respect of em-

ployees. At times it is necessary for her to obtain accurate personal information about the family life and home environment. It is obvious that this information will be given freely only to a person who is trusted and respected.

It is necessary also that employees feel free to go to the medical department. A nurse who scowls at employees when they come in the door, and criticizes them severely if they have ailments will have very few calls at the medical department for treatment or for advice. This is costly to industry since even the simple pin scratches may, as you know, become infected and often result in disability and compensation.

At the other extreme is the nurse who seems to have everybody visiting in the medical department most of the time. She chats and tells them good stories, and her office becomes the most popular rendezvous in the house. Obviously such a nurse will not last very long in her job.

### THE VALUE OF A SMILE

A nurse to be successful must habitually radiate happiness. Abraham Lincoln once said, "Most folks are about as happy as they make up their minds to be." The smile is the sign of happiness, and there are smiles and smiles! The smile I have in mind is one that radiates from within. It certainly is not the now-I-have-you grin of the wolf in Little Red Riding Hood. Perhaps this entire discussion could well be devoted to the importance of the smile in business. The acquisition of a smile can be cultivated like a personality. If you think smiling is a common practice, notice people on a bus or streetcar, or pedestrians whom you pass on the street. How many of them actually look happy?

Of course it is true that the industrial nurse may have troubles of her own. However, when she dons her uniform on the job she must throw aside her cloak of personal troubles.

The nurse has one of the biggest selling jobs in business. She must satisfy the doctor, the personnel manager, and other officials and department heads, as well as employees. This certainly takes selling ability!

She should not only radiate happiness through her smile but through leaving a cheerful word. A mere "Good morning," for example, will often change the day for an individual. He will look around and see that it is really a good morning. He will absorb part of her radiation of happiness and carry it to his associates.

The industrial nurse must develop tact and diplomacy in dealing with people. She must attain the ability to delve into the background and environment of individuals and determine cause and effect. While she is bandaging a finger she can find out the life history of an employee and perhaps determine why his work is poor or why he is having so many accidents. Perhaps his mind is on some problem at home which can be corrected through the aid of the personnel department or a social agency.

### TREAT EMPLOYEES AS INDIVIDUALS

The industrial nurse must handle people on a personal basis and avoid mechanical routine which may engender a poor attitude toward the medical department. Some professional people under pressure of time and work develop a cold exterior that is impersonal and not sympathetic. They acquire what may be called a professional mask. They overlook the little things that mean so much to the average person whose problems seem to him the greatest of any in the world.

Some people have an innate fear of medicine. Some people are actually nauseated by the smell of ether. Many have a fear of the sickroom and of anything that pertains to illness. With these persons the thoughtful nurse will use care, will be sympathetic, and will recognize the fears and soothe them.

In the routine of modern business

there is an inclination to handle individuals like machines. It is important that the nurse make every effort to personalize her contacts. She should acquire the ability to remember faces and names. This type of consideration develops self-confidence and peace of mind which results in better workmanship.

It is important that the nurse be a good listener. Employees at times have troubles which they need to discuss. The nurse should listen with interest to these stories; should separate the wheat from the chaff and bring undesirable conditions to the attention of the personnel manager. It is imperative that investigations be carefully planned to avoid betraying the confidence of employees. Many times where attention is needed in a department we purposely delay action until all possibility of suspicion that any particular individual has reported a condition is avoided.

A good first impression of the medical unit makes a lasting impression. One of the requirements of a service organization is promptness. Applicants should not have to wait too long for medical attention. In the first contact with an employee the nurse should establish a warm, friendly relationship which engenders confidence. She should explain the medical policy to the employee and encourage the use of the medical facilities.

The nurse must favorably impress all personnel in the organization, from the executives to the porters. She must be democratic and give each the same consideration. She must be very careful to talk in language that employees can understand and avoid technical terminology.

Part of the nurse's job is to make constructive suggestions to individuals. For example, it may be her duty to call to the attention of employees their failure to meet certain standards of personal hygiene. This information must be handled in an impersonal way so as not to offend the employee. The nurse must leave herself in a position as a real friend performing a service.

### ANALYZING ONE'S SELF

The points that have been covered will be restated here for emphasis, in the form of questions. I ask the industrial nurse to take out an imaginary mirror and answer *yes* or *no* to herself in reply to the following:

1. Do you get along with 90 percent of the people with whom you have contact—not because you are a "*yes*" person but by virtue of that something we term "personality"?

2. Do you listen attentively with understanding to employees who have grievances? Do you have a sympathetic ear?

3. Do you command respect and confidence to the extent that people talk to you freely?

4. Do you deal with people individually, recognizing what psychology calls the idiosyncrasies of man?

5. Do you radiate happiness; know how to smile; have a sense of humor and a cheerful outlook on things in general?

6. Do you attain your objectives through leadership, patient explanation, and understanding?

7. Do you have a sense of values? Can you pick the wheat from the chaff? And do you eliminate the gossip and act on the important things?

8. Are you democratic, human, and friendly? And do you treat all with the same fair consideration? Do you remember names?

9. Do you avoid discussing your own troubles on the job?

10. Do you give people a good first impression of the medical department? Do you give prompt service?

11. Are you tactful and diplomatic? Can you constructively make suggestions to people and not lose their friendship and respect?

12. Do you enjoy your work as public health nurse? Do you find a real satisfaction in your job?

If you can answer most of these ques-

tions positively, and have the professional qualifications necessary for the work, then I would say that you are potentially successful as an industrial nurse. All in all, the duty of the public health nurse in industry is to provide a service. This service is one of teaching people how to help themselves. If she is the right person for the job, she will at all times radiate enthusiasm for her work, and will keep alive the true spirit of adventure as a public health nurse in industry.

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NOTE: Acknowledgment is made by the author to James Watson, Director of Training, Montgomery Ward and Company, Chicago, Illinois, for source material used in the preparation of this paper.

Presented before the N.O.P.H.N. Industrial Nursing Section Round Table, Biennial Convention, Kansas City, Missouri, April 27, 1938.

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## WHERE TO FIND OTHER CONVENTION PAPERS

In *The American Journal of Nursing:*

MAY

Our Responsibility as Nurses to Our Profession—Effie J. Taylor, R.N.
The Outlook in Nursing Education—Nellie X. Hawkinson, R.N.
Building the University School—Elizabeth S. Soule, R.N.

JUNE

Individual Nurse's Responsibility for Her Own Security—Major Julia C. Stimson, R.N.
An American Student in London—Lulu K. Wolf, R.N.
Accrediting—A Coöperative Adventure—Clara Quereau, R.N.
Faculty Preparation for Curriculum Revision—Committee on Community Nursing.
What Part Should the Faculty Take in Curriculum Revision?—Sister M. Berenice Beck, R.N.
Award of Walter Burns Saunders Memorial Medal—Loyal Davis, M.D.
Problems Relating to the Merit System—May Kennedy, R.N.

(In addition to the biennial papers, the following articles of special interest to public health nurses will be published: First-aid Treatment of Fractures, by George H. Gildersleeve, M.D.; How and Why to Gather Facts, by Harold F. Clark, Ph.D.; A Simple Bandage Winder, by Barbara Orjas, R.N.; Free and Inexpensive Material—Food and Nutrition.)

JULY

Organizing for Better Community Service—C.-E. A. Winslow, Dr.P.H.

In PUBLIC HEALTH NURSING:

JULY

N.O.P.H.N. Model 1936-1938—Dorothy Deming, R.N.
The Staff Nurse Analyzes Her Own Work—Mrs. Luella Lewis, R.N.
Social Planning for Family Health—Bradley Buell.
Summaries of Round Tables.

LATER ISSUES

Mental Hygiene of the Family—William C. Menninger, M.D.
Nutrition of the Family—Williedell Schawe.
The Public Health Nurse in the Control of Tuberculosis—Mrs. Violet H. Hodgson, R.N.
Papers from several of the Round Tables will be published or abstracted.

The American Nurses' Association will publish complete Proceedings, which will include all papers given at the A.N.A. and Joint Sessions. The National League of Nursing Education will also publish its complete Proceedings.

# Home Care of Poliomyelitis Patients

By JESSIE L. STEVENSON, R.N.
Supervisor, Orthopedic Division, The Visiting Nurse Association of Chicago, Illinois

**The long view must enable each orthopedic public health nurse to see each patient as a unit in the life of his family and the community**

**Part II**

EVERY NURSE — institutional, private duty, and public health— should be familiar with the principles of orthopedic care as applied to poliomyelitis. She should be able to teach the mother bed posture, the correct application of splints or other apparatus, and the dangers of fatigue and of overstretching weak muscles. She should be able to demonstrate the warm bath for muscle soreness.

However, when massage and exercises are ordered, she should not be expected to assume the responsibility for giving these treatments either in the water or on the table unless she has had special preparation.

Before exercises are begun it is necessary to make a detailed muscle examination. This calls for an intensive knowledge of anatomy and muscle action and the ability to recognize trick movements.

By a trick movement, we mean performing a movement by substituting the action of a strong muscle in place of that of the weak ones. For example, the gluteus medius and gluteus minimus muscles move the hip sideward from the body. A patient with weakness of these muscles may perform the movement by moving his pelvis with his lateral trunk muscles. An exercise done in this manner would have no value in developing the weak muscles. The pelvis should be held in a fixed position in order to localize the muscle action.

It is not possible in these articles to give lists of exercises for poliomyelitis patients since exercises are worked out for each patient according to his muscle weakness.

There is no treatment for poliomyelitis patients which cannot be given in the poorest home provided the person who gives and teaches the treatment has had adequate preparation and experience.

"It should be emphasized again that it is not the equipment but the choice of suitable exercises and the technique of giving them that constitutes efficient treatment of paralyzed muscles. The kitchen table or even the kitchen floor have been utilized many times in homes where no other facilities were available."*

The home set-up for the various types of treatments will be described.

### WARM TUB BATH

The mother is taught to have the following articles in readiness:

Hammock or head rest for the tub
Bath towels
Soap and washcloth
Bathing cap if desired
Clean gown or pajamas
Clean sheets if bed is to be changed
Foot supports—padded bricks or boxes
Sandbags

If the bathroom is large enough, an ironing board makes a good work table.

The procedure is as follows: The mother may run the water in the tub

while the nurse is removing her wraps, washing her hands, and putting on her apron. If the child is on a frame, he may be carried on it to the bathroom and laid on the ironing board while his splints and gown are removed. He should be lifted into the tub in such a way as not to stretch or strain the muscles which have been supported in the splints. If one arm is involved, the child may use his good one to support the weak one at shoulder level. If one foot is normal, he may use it as a prop to support the weak one at a right angle.

While the nurse is giving the bath, the mother may straighten or change the bed and prepare the bathroom table. A cotton blanket and bath towel are spread over the ironing board. The support for the feet and a small towel pad for the knees, to prevent back-bending, are placed in the proper positions.

At first the child should remain in the water not more than ten or fifteen minutes. If he is afraid of the water, bright celluloid toys or carved soap will captivate his attention. Most children soon learn to love the water. The child is lifted out of the tub in the same manner that he is put in. He is dried quickly and lightly sponged with alcohol, and his splints are reapplied.

When exercises have been ordered by the physician, these may also be given in the tub. Bathtubs may be used only for small children. The bath would do more harm than good if the patient were put in a cramped position. If warm water is added during the bath, care should be taken not to burn the patient.

### TANK TREATMENTS

Galvanized iron tanks may be used for older children and adults. These may be constructed by a tinsmith at a nominal cost. The dimensions vary according to the size of the patient. The tank should be six or eight inches longer than the patient, and wide enough to allow arm spread when there is involvement of the arms. The best depth for all sizes is eighteen inches. The tank is placed on wooden sawhorses or a wooden platform to bring it to a convenient height for the worker. It may be filled by a garden hose attached to the kitchen or bathroom faucet, and the water siphoned off. If the tank has been made with a spigot, the water may be drained out more easily. Some families fill and empty the tank by means of an iron pipe attached to the plumbing. Others make a hole in the floor and drain the water through the hose into the laundry tubs in the basement. If these methods are used the tank must be kept in the same room all the time and is usually left set up. Families who have less space set the tank up in the kitchen when it is in use, and stand it up on end against the wall or on the porch when it is not in use (Fig. 5).

The most practical arrangement is to have the bed, the portable cart, and the top of the tank all the same height. If a simple collapsible stretcher is made, all lifting of the patient is eliminated, and adults as well as children may have the benefit of the water treatment.

The mother is taught to have the same articles in readiness as for the tub treatment. If the call can be made at approximately the same time each visit, the mother may have the cold water already run in the tank and may add hot water to bring it to the proper temperature after the arrival of the nurse. If the hot water is run in first, the room becomes steamed. The temperature of the water when exercises are ordered is usually from 90 to 96 degrees, F., but may be warmer during the period of muscle soreness. The water should be mixed so that the temperature is even throughout. It should be tested with a bath thermometer. If a thermometer is not available the mother may be taught to test it with her elbow.

Following is the procedure for trans-

Figure 5

Galvanized iron tank showing stretcher lowered and hammock head rest

porting the patient from the bed to the tank when the family has a portable cart: Wheel the cart parallel to the bed. Turn the patient on to the cart. Wheel the cart parallel to the tank. Roll the patient on to the tank stretcher which is at the same level. Lower the tank stretcher and float the patient on to the hammock. Remove the stretcher or allow it to remain in the bottom of the tank.

When the treatment is completed, float the patient on to the stretcher and raise the stretcher to the top of the tank. The patient may be dried on the stretcher and rolled back on to the cart which has been prepared in the meantime.

If the family do not have the portable cart and the patient is on a single bed, the bed may be wheeled alongside the tank in a similar manner.

Naturally the arms and legs must be properly supported in the water. Covered bricks may be used for this purpose. A milk bottle filled with water may be used to support the arm at shoulder level. Care should be taken to prevent chilling when the patient is removed from the tank.

### TABLE TREATMENTS

The kitchen or dining-room table may be used for massage and exercises, the selection of a place depending upon the size of the patient. The table should be in a warm room. The mother is taught to have it in readiness. Cover it with a clean blanket kept for that purpose. The foot support and small pad to be put under the knees should be in place. Sandbags placed lengthwise of the legs may be used if the legs tend to roll outward from the hips. Oil, cocoa butter, cold cream, or powder may be used in giving the massage. Oils or creams are better if the skin is dry, but this is a matter of personal preference.

The Hoffa massage is the type most commonly used for poliomyelitis patients. The massage is given very gently, especially for new cases and the strokes are in an upward direction.

A piece of brown wrapping paper powdered with talcum powder may be placed under the patient when the exercises are given. This helps to overcome friction and makes it possible to do the exercises more accurately.

### TREATMENTS IN BED

When no large table is available or when the patient is an adult, it may be necessary to give the treatment in bed. If the bed is low, it should be elevated

on blocks of wood as previously described.* The same general rules for correct posture should be followed.

A piece of three-ply veneer board, shellacked and sandpapered may be placed under the patient for the exercises. Powdering the board with talcum powder prevents the legs or arms from sticking and helps to overcome friction when the exercises are being given. The heels or bony prominences may rest on powdered sponge rubber (Fig. 6).

### WRITTEN INSTRUCTIONS

A written list of instructions including the list of exercises should be in every home in which the parents read and speak English. This list should be written in terms that the family can understand. The position for the exercise should be indicated, and all the exercises for that position written under the corresponding heading. A piece of cardboard five by eight inches in size may be used to write the instructions; this tears less easily than paper. It should be put where it will not be lost. Many mothers hang it above the tub, bed, or table. The instructions are revised or rewritten as the patient's condition changes.

*See previous article in PUBLIC HEALTH NURSING May 1938, page 276.

### RETURN DEMONSTRATIONS

The mother is gradually taught to help with the treatment. It is better to teach her a few exercises at a time and have her demonstrate them back in order to make sure that she is doing them accurately. She is likely to be overwhelmed if she tries to learn the entire treatment at once. Teach her to have the child do each exercise slowly and to relax after each. Sometimes it is hard for a small child to get the idea of relaxation. Tell him to make the muscle "soft," or to let it go to sleep, or to pretend that it is a rag doll.

Stress the dangers of fatigue in giving the exercises. If the last exercise is not done as well as the first, too many exercises have been given or they have been given too rapidly.

Be sure that the mother knows how to prevent trick movements. Have her demonstrate a part of the treatment or the entire treatment at stated intervals.

Encourage the patient and family by pointing out improvement, no matter how slight.

### BUILDING UP THE MORALE

The importance of teaching the patient and family the details of orthopedic care cannot be stressed too much. This must be done in terms that the fam-

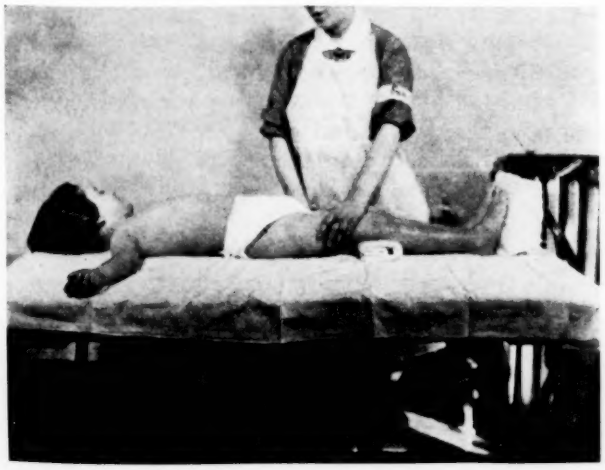

**Figure 6**

**Table treatment showing correct support when massage is given**

ily can understand. When the principles of orthopedic care are carried out twenty-four hours a day with the same care with which surgical asepsis is practiced—then we shall have given muscles a chance. Nonsupport of weak muscles even for a few minutes is like flogging the defenseless.

Parents and patients have a right to know the reason for all the things we ask them to do, and if they are taught the reasons, they will be careful never to break technique. Children as young as five years of age can understand simple explanations of their muscle weakness and will take great pride in helping to carry out directions. We need to use all our resources to impress families with the worthwhileness of undergoing the discipline of long-drawn-out treatment. If we do that, many of them will not have to be brave later on, for they will have been restored to normal muscle function.

#### "ISN'T IT CRUEL?"

The first reaction of some parents is, "Isn't it cruel to tie the child down on a Bradford frame?"

The best answer is another question: "Which is more cruel—to tie him down for a few months now, or to let him sit up and crawl about now and develop deformity and lameness later?"

A little child makes an adjustment very quickly, and we can show the mother many ways of keeping him interested and entertained. A boy eight years old lay on his portable cart on the back porch and was the coach while his playmates played football in his back yard.

The problem of what to do for a four-year-old girl who lies in her crib on a Bradford frame with both arms and legs in splints at first seems hopeless. One mother solved it with the help of the nurse in this way: Brightly colored balloons—Mickey Mouse, Donald Duck, and other favorites—were tied to the bars at the foot and sides of the crib. A picture book was clipped on a wire strung across the crib. The resourcefulness of the mother helped to develop the child's vivid imagination.

Older patients can be stimulated to develop new interests. Stamp collections, short-wave radio sets, and airplane models have helped to make constructive use of this enforced leisure. Some patients should not be encouraged to undertake activities requiring considerable mental effort during the first few months, or the result will be increased nervousness and physical fatigue. The mother should watch that the child stops before he gets tired.

The nurse needs to have vision, imagination, and controlled sympathy to help the patient and family to make the psychological adjustment which is required during the long convalescence.

#### "HOW LONG MUST HE STAY IN BED?"

A question frequently asked in the beginning and repeated on later visits is, "How long will Johnny have to stay in bed?"

The best answer that we have heard was given by a physician:

"It depends on what you want. If you don't mind his being lame, he may get up very soon with braces. But if you want him to have the best chance of being as well as possible, he should stay down several months more. When he grows up, you will want him to feel that you have giver him the best chance, won't you?"

Another question which puzzles some parents is, "How can his muscles get strong when he wears the splints all the time? Shouldn't he keep exercising them to get them strong?"

This may be answered by various explanations:

"You would not expect a sick person to do a hard day's work or to get up and walk ten miles the first day after a long illness. He would do a little each day

until his strength was built up. Mary's muscles are 'sick.' They must have rest and gradual exercise to make them stronger."

Or a normal muscle may be compared to a strong rope which can carry a heavy weight. The weak muscle is like a few slender strands which can carry a small weight but would give way under the load which the rope carries. In emphasizing the dangers of stretching and tiring muscles, we may compare them to bands of elastic which give way under constant stretching.

When parents tell of various forms of quackery suggested by neighbors, we may ask, "Where do you take your car to be repaired? If you take your car to an expert mechanic, don't you think you should give your child just as much consideration by following the expert advice of the doctor?"

### THE LONG VIEW

Thus far we have focused our attention on a close-up view of the details of the early convalescent care of poliomyelitis patients. The preparation and experience of the orthopedic public health nurse should give her the long view in order that she may see the entire treatment in its true perspective.

The basic principles of orthopedic care—rest, and protection of weak muscles from overstretching—should be applied from the minute the diagnosis has been confirmed, and extend throughout the acute stage and the early and late convalescent stages of the disease. Throughout the entire course of treatment we must never lose sight of the fact that our ultimate goal is functional use of the muscles. The fact that the muscle test shows a gain of a few points means nothing unless this gain can be translated into practical use.

When the legs are involved, our efforts are directed toward teaching the patient to stand, to balance, to walk with the minimum of limp, to climb stairs, and to sit down and get up out of a chair. The nurse who has seen the unsightliness of a limp caused by weak hip extensor and abductor muscles is determined that these muscles shall have opportunity for maximum recovery.

Unless one has been deprived of the use of one or both arms, he has no conception of what it means to a person to be able to feed himself, to perform simple toilet functions such as brushing his teeth and combing his hair, to turn the pages of a book, or to write.

The long view enables the nurse to visualize the relative importance of all of these muscle groups in the daily activities of each patient and to direct her efforts toward functional use of these muscles in each stage of the treatment.

The value of months of careful teaching and treatment of poliomyelitis patients during the period of lying in bed is of no avail unless these same principles of orthopedic care are continued when the patient is permitted to be up. Activity, particularly in the beginning, must be carefully graded and always kept within fatigue limits.

The long view must also enable each orthopedic public health nurse to see each patient as a unit in the life of his family and the community. A complete program for the care of the handicapped must include physical care, education, vocational guidance, training, and placement. Without social adjustment of patient and family, none of this program can be effective.

Even though the best of physical care is available, there will always be a residue of severely paralyzed poliomyelitis patients who will need special facilities for education and vocational training. Many of the milder cases will also need some of these provisions during some phases of their treatment. Therefore, public health nurses should be familiar with the resources of their communities in meeting these needs.

Adequate physical care for poliomye-

litis patients means that many children will never need these special facilities because they have been restored to normal or nearly normal muscle function. The challenge to public health nurses is that if they are equipped with adequate orthopedic preparation and experience, they may help to solve by elimination many of the problems that confront us in the care of the handicapped.

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## AMERICAN NURSES' ASSOCIATION

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# Report of N.O.P.H.N. Sections

## 1936-1938

SINCE reports of the activities of the three Sections of the N.O.P.H.N. for the biennial period 1936-1938 appeared in *Listening In*, April 15, 1938, we are publishing only a brief resumé of the program and business meetings of these Sections at the Biennial Convention, together with the list of members of the Executive Committee of each Section for the coming biennial period.

## BOARD AND COMMITTEE MEMBERS' SECTION

Represented at the Kansas City Biennial Convention were board members from 18 states, from as far west as Utah to the states of the Eastern Coast—New Jersey, New York, Pennsylvania, Rhode Island, and Massachusetts; from as far north as Minnesota to Tennessee in the south. It is impossible to give exact numbers, for in a convention of such size with such diverse attractions, and with people arriving and leaving on different days, there was no opportunity for taking an accurate census.

The welcoming tea at the Woman's City Club, at which the board of directors of the Kansas City Visiting Nurse Association were hostesses, was one of the most enjoyable occasions of the convention.

There were a few meetings planned particularly for the board members, among them a round table for the discussion of mutual problems. Many regrets were expressed that this discussion had to be limited to an hour and a half. And all who attended would like to make a definite recommendation to the next program committee that more time should be allowed for a meeting of this nature.

The Round Table on Publicity gave practical and interesting suggestions on channels and techniques for interpreting public health nursing to the public.

There was a board and committee members' dinner at the delightful Kansas City Country Club, at which guests had the opportunity of hearing about the history of the U. S. Public Health Service and what the layman can do to further the federal health program. There was also given an intimate picture of the work of a county nurse on her daily job.

At the business meeting Amelia Grant, the retiring president of the N.O.P.H.N., spoke, and Grace Ross, the new president, said a few words. This meeting was the occasion for hearing the secretary's interesting and impressive report of her own activities and those of the Section during the last two years. The following officers and directors for the Section were elected for the period of 1938-40:

### EXECUTIVE COMMITTEE FOR THE NEXT BIENNIAL PERIOD

*Chairman*—Mrs. Frederick S. Dellenbaugh, Jr., Chestnut Hill, Mass.
*Vice-Chairman*—Mrs. S. Emlen Stokes, Moorestown, N.J.
*Lay Directors*—Helen M. Alvord, Greenwich, Conn.; Mary Roberts Coles, Philadelphia, Pa.; Mrs. Walter Berry, Caspian, Mich.; Mrs. R. Livingston Ireland, Cleveland, Ohio; Mrs. Joseph Lilienthal, New York, N.Y.; Mrs. Samuel Sawyer, Kansas City, Mo.; Mrs. William Getz Thuss, Birmingham, Ala.; Mrs. J. P. Weyerhauser, Tacoma, Wash.
*Nurse Directors*—Ruth Fisher, Plainfield, N.J.; Anna T. Hooley, Albany, N.Y.; Pearl McIver, Washington, D.C.; Sue Nickerson, Bryan, Texas.

## SCHOOL NURSING SECTION

The School Nursing Section was active at this Biennial Convention in a number of different ways. Prior to the convention, Marie L. Swanson, State Supervisor of School Nursing, New York State Department of Education, conducted an excellent Institute on School Nursing which was attended by 71 people, with as many more turned away. This attendance speaks well for the interest of the nurses in their desire for further education in their field. The supervisors of school nursing services were greatly interested in the Round Table on "Current Problems in School Supervision," which was attended by nurses from 20 different states.

A demonstration of a school health examination was given by Gertrude E. Cromwell, Supervisor of Health Education and School Nursing, Des Moines (Iowa) Public Schools, Department of Health, and was followed by a panel discussion on the subject.

Twenty-eight states were represented at the luncheon of the School Nursing Section, at which Dr. Mayhew Derryberry, Public Health Statistician of the United States Public Health Service, spoke on implications of the study "Physical Defects—The Pathway to Correction," published in 1934 by the American Child Health Association.*

The following resolutions were passed by the Section:

1. RESOLVED, That we express our appreciation to the PUBLIC HEALTH NURSING magazine for the materials on school nursing that have been published during the past two years, and for the many other articles not on school nursing that have been needed and helpful.

2. RESOLVED, That we express our thanks for the opportunity of presenting the problem of school-nurse education to the Council of Course Directors.

3. RESOLVED, That we record our interest in having the latest educational principles incorporated in the revised *Manual of Public Health Nursing* in the chapter on school nursing.

4. RESOLVED, That our membership appreciates the canvass of the membership that resulted in the continuation of the school health section of the magazine.

5. RESOLVED, That we continue our efforts to secure committees of nurses now engaged in school nursing, with experience in making successful visits of other types, to be appointed to work out materials helpful in improving school nursing visits. (Repeated from 1936.)

6. RESOLVED, That we heartily commend the elaboration of the Biennial Convention program to include an Institute on School Nursing and a Round Table for Supervisors of School Nursing Services. Many helpful discussions were the result. (The resolutions would not be complete without an expression of appreciation of the forceful and challenging conduct of the Institute by our colleague, Marie L. Swanson.)

7. RESOLVED, That we acquaint the N.O.P.H.N. with our appreciation of their steadfast interest in and support of our school nursing program, and that because of their continued efforts in our behalf we acquaint them with the following expressed needs:

*a.* The need for assistance in securing materials on the subject of school nursing for school administrators.

*b.* The need for educational facilities for training school nurses now in service and for preparing supervisors for supervision.

*c.* The need for methods of determining the present status of school nursing supervision in the United States and in individual states.

*Obtainable from the American Public Health Association, 50 West 50 Street, New York, N.Y.

**EXECUTIVE COMMITTEE FOR THE NEXT BIENNIAL PERIOD**

*Chairman*—Marie Swanson, R.N., Albany, N.Y.
*Vice-Chairman*—Mellie Palmer, R.N., Minneapolis, Minn.
*New Nurse Directors*—Gertrude Cromwell, R.N., Des Moines, Ia.; Kathleen Leahy, R.N., Seattle, Wash.
*New Non-Nurse Director*—Dean Franklin Smiley, M.D., Ithaca, N.Y.
*Nurse Directors holding over from last biennial period*—Anna Heisler, R.N., San Francisco, Calif.; Dorothy Wright, R.N., San Diego, Calif.
*Non-Nurse Director holding over from last biennial period*—Anne Whitney, Milton, Mass.

## INDUSTRIAL NURSING SECTION

At least 200 people attended one or more of the four sessions dealing with industrial nursing subjects held during the week of April 24, 1938, at the Biennial Convention in Kansas City, Missouri.

An excellent demonstration of the nurse's job in industry was given on April 26 by the Kansas City Industrial Nurses' Club, with Ann Fogg of the American Can Company in the principal role.

The Round Table of the Industrial Nursing Section on April 27 was devoted to the following topics: "Selling Nutrition to the Industrial Worker," by Martha Pittman, Food Economics Department, Kansas State College, which was discussed by Mabel Beeler, industrial nurse with the Federal Reserve Bank in Kansas City; and "Getting Along with People," by L. R. Sherrell, Personnel Director, Montgomery Ward and Company, Inc., Kansas City, Missouri. (See page 385 for Mr. Sherrill's address.)

A large group attended the industrial nurses' luncheon on April 27 to hear Dr. C.-E. A. Winslow of Yale University discuss in his inimitable way the subject, "If I Were an Industrial Nurse." At this luncheon, too, Eleanor Mumford, representing The National Society for the Prevention of Blindness, spoke briefly on the service of that organization and its value to industry.

The business session passed a resolution recommending to the N.O.P.H.N. Board of Directors that a study be made of essential subjects to be included in public health courses for preparation of nurses for industrial work.

The trend of thought throughout these meetings emphasized the need for:

1. Better prepared nurses for industry.
2. Education of employers in more careful selection of nurses.
3. Inclusion of subjects, both in the basic nursing-school period and in connection with public health nursing courses, which will give the nurse a better preparation for her work in industry.
4. Employment of industrial nurse consultants who can interpret the problems of the nurse in industry and bring about closer coördination of her activities with the other health and welfare agencies in the community.

As these meetings progress, one sees a definite trend toward better understanding of problems confronting nurses in industry by those engaged in other phases of public health nursing. This can be justly attributed to the active interest of the N.O.P.H.N. and its increased membership of industrial nurses.

### EXECUTIVE COMMITTEE FOR THE NEXT BIENNIAL PERIOD

*Chairman*—Joanna Johnson, R.N., Milwaukee, Wis.
*Vice-Chairman*—Catherine Dempsey, R.N., Cambridge, Mass.
*New Nurse Directors*—Mrs. Blanche Lloyd Frances, R.N., Reading, Pa.; LaVona Babb, R.N., St. Joseph, Mo.; Marion Dowling, R.N., Ridgefield, N. J.; Hortense E. Gruber, R.N., New York, N.Y.
*New Non-Nurse Directors*—A. L. Brooks, M.D., Detroit, Mich.; W. Graham Cole, New York, N.Y.
*Nurse Director holding over from last biennial period*—Mrs. Kathryn M. Page, R.N., San Francisco, Calif.
*Non-Nurse Directors holding over from last biennial period*—W. H. Cameron, Chicago, Ill.; Mrs. Austin T. Levy, Harrisville, R.I.
*Honorary Life Member*—Mrs. Marion T. Brockway, New York, N.Y.

**Those agencies which became Honor Roll members during the month of May will be listed in the July issue, together with the members for June.**


### HANDBOOK ON SOCIAL HYGIENE

Edited by W. Bayard Long, M.D. and Jacob A. Goldberg, Ph.D. 442pp. Lea and Febiger, Philadelphia, 1938. $4.

The contents of this volume amply justify its title. Each of the nineteen contributors has given definite guidance on the particular phase of social hygiene upon which he or she has written. Moreover, each of the contributors is by interest, preparation, and experience, eminently qualified to offer guidance.

The editors have arranged the material so that the common sense aspects of coördination in medical, public health, hospital, and social work practice for the control and prevention of syphilis and gonorrhea are established beyond question.

The contributors include an educator, dermatologists, syphilologists, a neurologist, a gynecologist, a pediatrist, an ophthalmologist, urologists, a hospital administrator, a public health official, a laboratory director, an internist, nursing administrators, a social worker, and a sociologist.

This handbook is a valuable addition to the literature in each of the fields of service represented. Presenting what could be the contribution of each group to the problem as a whole is a challenge to all. Technical problems are described with a clarity that will be gratifying to readers of less than specialist standing.

Three chapters are written by well known nurses. The opportunity of the nurse in case-finding and case-holding or follow-up, particularly with women and children, is emphasized. Several brief case histories are given in illustration. Readiness to take advantage of opportunities for presenting sound sex and social information is considered the duty of the nurse.

A digest of state laws with respect to marriage and to reporting, prevention, control, and treatment of the so-called venereal diseases; the rules and regulations of local departments of health; "privileged communications" (confidential status of certain information), and problems of workmen's compensation make up the closing chapter.

This book is dedicated to Dr. William Freeman Snow, an outstanding figure in the American social hygiene movement, who has written the opening chapter.

The illustrations are good, the type is clear, and a list of references is given at the end of each chapter.

EDNA L. MOORE, R.N.
*Toronto, Canada*

### FIRST AID TEXT-BOOK

By The American Red Cross. 256pp. P. Blakiston's Son and Company, Philadelphia, revised edition, 1937. Cloth, $1; paper, 60c.

A new revision of the American Red Cross First Aid Text-Book became necessary because of advancement in surgical practice in the treatment of injuries. Many changes are included in the 1937 edition, and most important of these is the acceptance of the principle of fixed traction in the emergency treatment of fractures of arms and legs. Especially with the increase of automobile accidents, fractures are occupying a place of greater importance in both home and industrial life, and it therefore seemed advisable that a new text be made to conform with the most modern methods.

The book contains several new illustrations—now amounting to 114—which will prove a help in interpreting many

of the mechanical procedures that are often hard to understand from the printed page.

In bringing the book up to date, the authors have increased its effectiveness as a help to both students and teachers in developing a technique of first aid treatment and transportation for injured persons.

EDWARD R. GRANNISS,
*National Safety Council,*
*Chicago, Illinois*

### COSTS OF MEDICAL CARE

**The Cost of Adequate Medical Care.** By Samuel Bradbury, M.D. 86pp. University of Chicago Press, Chicago, 1937. $1.

**Hospital Care and Insurance.** By C. Rufus Rorem, Ph.D. 71pp. American Hospital Association, Chicago, September 1937. 50c.

Dr. Samuel Bradbury, prominent physician in Philadelphia, has taken the estimates published by previous authorities as to the services required for adequate medical care and has estimated their costs. His book works out in a very interesting way the relations between the services of general practitioners, specialists, hospitals, laboratory and x-ray work, etc., and shows the relative costs of these in terms of usual minimum fees or charges for such services. Nursing is by no means neglected. The very substantial part which nursing and attendant service play in the care of disease and in its costs is fully brought out in his tables. Nursing, for instance, is estimated to constitute over 26 percent of the total cost of care in the diseases of the respiratory group, and slightly more than this in diseases of the acute communicable category. An estimate of the division of nursing care between graduate nursing, attendant nursing, and visiting nursing on an hourly basis (page 17) will be of particular interest to the readers of this journal.

Dr. Rufus Rorem, in his last pamphlet on the movement which he has been leading in the United States, has brought together much valuable information in compact form. Within five years, voluntary insurance against the cost of hospital care has enrolled more than a million beneficiaries in non-profit organizations in over 40 cities. The movement's rate of growth seems to be accelerating. The approved standards with which agencies of group hospitalization should conform, the present extent of the movement, its costs, its administrative problems, and examples of existing agencies are set forth effectively. Dr. Rorem's pamphlet is published under the authority of the American Hospital Association and distributed by that organization.

MICHAEL M. DAVIS, Ph.D.
*New York, New York*

### CHATS WITH A PUBLIC HEALTH NURSE

By Elizabeth H. Rath. Drawings by Florence Reidel. Public Health Nursing Association, 519 Smithfield Street, Pittsburgh. 35 cents.

The Public Health Nursing Association of Pittsburgh, Pa., has issued a collection of "Chats with a Public Health Nurse" which should offer helpful suggestions to those responsible for the publicity and fund-raising of similar agencies everywhere. A great deal of work has evidently gone into the writing of these sketches by Elizabeth H. Rath, and the illustrative drawings by Florence Reidel liven up the stories and provide an added touch of humor.

In the foreword, Helen V. Stevens, Executive Director of the Pittsburgh Association says: "For public health nurses, as for others in the field of social welfare, telling the story of the work they do is one of their hardest tasks. Yet tell it they must, in a way that enlists the understanding, sympathy, and active interest of the community . . . Miss Rath has interpreted the work of the public health nurse with unusual effectiveness."

In a series of articles, as brief as 200 or 250 words each, Miss Rath has packed much valuable public education about nursing, a great deal of human in-

terest material, and the general spirit of the nursing staff. It is just the sort of material that is adapted for a daily or weekly newspaper column. These are more than mere case stories, for they have all the effectiveness of such true life dramas plus a great deal of statistical and health-education material.

DAVID RESNICK
*New York, N. Y.*

### "QUESTIONS TO ASK ABOUT A CAMP"

What should parents know about choosing the best summer camp for their children? The questions which should be carefully considered in making a decision regarding any camp are given in an article by Fred C. Lasch under this title, in *Parents' Magazine* for April 1938. They concern such points as the qualifications of the director, the primary purpose of the camp, the location and equipment, the philosophy of the camp, the general qualifications and special training of the counselors, the diet, health, and safety precautions, schedule, activities, and the spirit and morale of the camp. The importance of early registration—not later than June 1 and preferably earlier—is stressed. Some of the results to be expected from a camp are suggested.

### THE USE OF ALCOHOL

Nurses and teachers frequently request educational source material on the effects of the use of alcohol. "The Physiological and Psychological Effects of Alcohol and Their Social Consequences," by Mary Lewis Reed, which appeared in *The Trained Nurse and Hospital Review* for October and November 1937, has been reprinted in pamphlet form by the Lakeside Publishing Company, 468 Fourth Avenue, New York, at a cost of 15c.

The articles are based entirely upon secondary sources, quoting liberally from various reports and opinions on the subject. The selection of the hazardous open well as an illustration of "Nature's gift" in the first edition of the pamphlet is unfortunate. The comprehensive bibliography appended to the articles will be especially helpful to readers.

## RECENT PUBLICATIONS AND CURRENT PERIODICALS

### ORTHOPEDICS

PROCEEDINGS OF SIXTEENTH ANNUAL CONVENTION OF THE INTERNATIONAL SOCIETY FOR CRIPPLED CHILDREN. *The Crippled Child,* June 1937.

This issue of *The Crippled Child* is full of helpful material on surveys, programs, functions of various workers, special problems, and other aspects of the work with crippled children.

SERVICES TO CRIPPLED CHILDREN. The First Annual Report of the Utah State Crippled Children's Division, Utah State Board of Health, July 1936-July 1937.

This mimeographed report includes typical case stories and numerous tables listing cases according to diagnosis and geographic distribution. Several pages are devoted to the administrative activities and a similar amount to the educational phase of the program.

RESPONSIBILITY FOR THE NONRESIDENT CRIPPLED CHILD. *The Child,* U. S. Children's Bureau, Washington, D. C., September 1937, p. 58.

THE CRIPPLED CHILD. Ohio's Plan for Care, Treatment, and Education. Mabel E. Smith, Crippled Children's Bureau, Division of Charities, Department of Public Welfare, Columbus, January 1931. 55pp.

The introduction gives a brief history of Ohio's care of crippled children since 1872. The present plan includes service in three departments: (1) the State Department of Education, which supervises special classes and provides vocational work for crippled children over 16 (2) the State Department of Health, which registers crippled children and conducts clinics (3) the State Department of Welfare, which arranges for, supervises, and pays for treatment through money collected from counties.

CARE AND EDUCATION OF CRIPPLED CHILDREN. Bulletin No. 4, Wisconsin State Department of Public Instruction, Madison, June 1937. 16pp.

Brief, clear statement and evaluation of existing facilities for medical care and education of crippled children in Wisconsin.